UNDERSTANDING FAMILY MEMBERS’ EXPERIENCES OF FACILITATED FAMILY PRESENCE DURING RESUSCITATION

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation
of ERLA KAY CHAMP-GIBSON find it satisfactory and recommend that it be accepted.

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Facilitated family presence during resuscitation (FFPR) is a practice in healthcare that provides family members the opportunity to be present with their loved one during resuscitation. The distinct aspect of FFPR is the presence of a family facilitator (FF) who remains with, supports, and guides family members (FMs) throughout the duration of the resuscitation event. Research regarding family presence has included discussions about risks and benefits with perspectives from FMs, patients, nurses, and physicians. However, little research focused on the role of the FF and none focused on understanding the family members’ experience of the FF present with them during the resuscitation. For this study, the researcher used a philosophical hermeneutic approach and interviewed nine participants at least 3 months after their FFPR experience. Interviews were audio-recorded, transcribed, and analyzed by a team of philosophical hermeneutic researchers using an interpretive analysis methodology to identify themes and patterns in the data. Two overarching patterns were revealed: being guided through a surreal and sacred time and contributing to a successful resuscitation. FMs considered the resuscitation successful if they knew everything possible was done for the patient, understood the meaning of the patient response to interventions, and were present with the patient during and at time of death. The findings from this study concur with current research recommending the practice of family presence during resuscitation. However, this study highlights the importance
of a FF to guide and support FMs through the resuscitation process and the importance of the FM being present as part of their own coping and grieving process.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENT</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xi</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>4</td>
</tr>
<tr>
<td>Specific Aim and Research Question</td>
<td>5</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Feasibility Study</td>
<td>5</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>7</td>
</tr>
<tr>
<td>Facilitated Family Presence during Resuscitation (FFPR)</td>
<td>8</td>
</tr>
<tr>
<td>Historical Development</td>
<td>11</td>
</tr>
<tr>
<td>CPR, Technology, and the Deathbed Ritual</td>
<td>11</td>
</tr>
<tr>
<td>Survival Rates</td>
<td>13</td>
</tr>
<tr>
<td>Slow Code</td>
<td>13</td>
</tr>
<tr>
<td>Code Status</td>
<td>14</td>
</tr>
<tr>
<td>Safe Place</td>
<td>16</td>
</tr>
<tr>
<td>Landmark Cases</td>
<td>17</td>
</tr>
<tr>
<td>Supporting Research</td>
<td>22</td>
</tr>
</tbody>
</table>
Role of the Family Facilitator ................................................................. 22

Perspectives of Family Members ......................................................... 24

  Knowledge and understanding .......................................................... 25

  Opportunity to participate ............................................................... 25

  Advocate for the patient .................................................................. 25

  Fulfillment of vows ......................................................................... 26

  Facilitation of grief ......................................................................... 26

Perspectives of the Patient ................................................................. 26

Perspectives of Resuscitation-Team Members ................................... 27

Perspectives of the Institution .......................................................... 28

Summary ............................................................................................ 28

Theories ............................................................................................... 29

  Crisis Theory ................................................................................ 29

    Crisis intervention model .............................................................. 33

  End-of Life Decision-Making Theory .............................................. 34

    Traditional approaches to decision making .................................. 35

    Shared decision-making model .................................................... 36

      Experiential evidence ................................................................. 37

      Domains ................................................................................ 37

  Vigils for the Dying Theory ............................................................ 39

    Functions of the death-bed vigil ................................................... 41

      Establishing death .................................................................... 41

      Protective watchfulness ............................................................ 41
Support for the dying person’s soul .................................................. 42
Management of inner turmoil and emotions ............................... 43
Resistance to control by others ...................................................... 43
Rites of passage ........................................................................... 44
Conclusion .................................................................................... 45

3. METHODOLOGY ........................................................................ 46

Philosophical Hermeneutics .......................................................... 46
Philosophical Background ............................................................. 47
Phase I: Dilthey ............................................................................ 48
Phase II: Husserl and Heidegger ................................................ 49
Edmund Husserl .......................................................................... 49
Martin Heidegger ......................................................................... 49
Phase III: Gadamer ....................................................................... 50

Key Methodological Terminology ................................................. 51

Methods ....................................................................................... 54
Feasibility Study .......................................................................... 55
Purpose ......................................................................................... 55
Process ........................................................................................ 55
Summary ....................................................................................... 57

Recruitment and Sample .............................................................. 57
Human Subjects ............................................................................ 59
Data Collection: The Hermeneutic Interview ................................ 59
Analysis Process .......................................................................... 61
Data collection and transcription .................................................................61
Interpretation of data ....................................................................................61
The hermeneutic circle ..................................................................................62
The reader .......................................................................................................63
Establishing Trustworthiness of Findings: Criteria for Evaluation ..........64
Rigor .............................................................................................................64
Strengths .......................................................................................................64
Limitations ....................................................................................................65
Bias and prejudice .........................................................................................65
Personal bias and prejudice revealed .........................................................66
This researcher’s bias changed by this study .............................................66

4. FINDINGS AND INTERPRETATION ..............................................................68
Description of Participants ..........................................................................68
Setting the Scene: The Surreal and the Sacred Nature of CPR .................70
Surreal Time ..................................................................................................70
Sacred Space ................................................................................................72
Pattern I: Being Guided Through a Surreal and Sacred Time .................75
Being Invited and Ushered In ......................................................................77
Being Guided Through ................................................................................78
Being Included in Decision Making .............................................................80
Pattern II: Contributing to a Successful Resuscitation .........................81
Honoring the Relationship ..........................................................................81
Advocating for the Patient ..........................................................................83
LIST OF TABLES

1. Overview of Participants’ Experiences.................................................................69
LIST OF FIGURES

1. Figure 1; Diagram of facilitated family presence during resuscitation..................................75
DEDICATION

To my very supportive, encouraging, and patient family

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CHAPTER ONE

INTRODUCTION

Facilitated family presence (FP) during resuscitation (FFPR) is a relatively recent practice in healthcare. The first documented case was in 1982 and since then the practice has gradually been recognized as a beneficial practice. FP during resuscitation (FPDR) is the practice of allowing family members (FMs) to be in the room or at the bedside of a patient receiving cardiopulmonary resuscitation. FFPR provides a family facilitator (FF) to be with FMs while present in the room or at the bedside of a loved one during resuscitation. Even though FFPR is a practice endorsed by many professional organizations, it is not a universal practice.

Statement of the Problem

Cardiopulmonary resuscitation (CPR) is a lifesaving intervention for sudden cardiac failure, supported nationally and internationally in healthcare institutions for more than 50 years. During this time, procedural steps regarding the implementation of CPR have been evaluated and revised periodically to improve patient short-term and long-term survival rates (McNally et al., 2011). However, even with technological advances and procedural improvements, short-term and long-term survival rates continue to be low in the adult population (ranging from 2 to 15%) with uncertain outcomes (McNally et al., 2011); a trend also noted in the pediatric population (2–12%), with teenagers having a greater chance for survival than younger children (Jayaram, McNally, Tang, & Chan, 2015).

Traditionally, with the initiation of CPR and the increased use of technology and invasive procedures in acute-care settings, FMs are prevented from being with the patient during resuscitation. During CPR, FMs are taken to a safe place to wait while the resuscitation team works with the patient. While waiting, FMs may receive periodic updates, but they do not know
what is happening between updates or how the patient is doing during CPR. The safe-place practice is increasingly considered problematic for several reasons. First, FMs do not know how the patient is responding to resuscitation interventions (Fanslow, 1983; Hanson & Strawser, 1992; Robinson, MacKenzie-Ross, Campbell Hewson, Egleston, & Prevost, 1998). Second, the resuscitation team leader makes decisions about continued interventions or cessation of resuscitation without the FM being present to advocate for continuation or cessation of CPR (Robinson et al., 1998). Third, if the patient dies, FMs miss the opportunity to see the patient or say good-bye before time of death, which may prolong the grief process (Fanslow, 1983; Hanson & Strawser, 1992; Robinson et al., 1998; Steinhauser et al., 2000).

About 30 years ago, this safe-place practice two separate incidents challenged this practice, becoming landmark events promoting change in practice. In each of these incidents, spouses demanded to be present during CPR (Hanson & Strawser, 1992). Hence, they questioned and challenged traditional practice, and healthcare professionals (HCPs) developed a new practice, FPDR, that involved the FM as a member of the resuscitation team (Hanson & Strawser, 1992). Since then, FPDR has been promoted as a beneficial practice for FMs, recommended by national organizations such as the Emergency Nurses Association (ENA, 2005) and the American Association of Critical-Care Nurses (AACN, 2004). In spite of research revealing the positive benefits of FP, resistance to adoption of family-presence policies and practices continues. The primary reason given for HCPs’ resistance is that the FM might observe or think mistakes were made, which could result in litigation. Other reasons given by HCPs for resistance to FP include: (a) FM(s) might disrupt the CPR process; (b) limited space is available in the room for additional people; (c) CPR team members might experience performance anxiety, which may delay interventions; (d) CPR team members do not want to be concerned about the
FM in addition to the patient; and (e) CPR may be too traumatic for FMs to witness (Davidson, Buenavista, Hobbs, & Kracht, 2011; Duran, Oman, Abel, Korziel, & Szymanski, 2007).

As the practice of CPR advanced with the addition of technology and evidence-based practice, so has the care of FMs during CPR. Because of the tenuous nature of the crisis, FMs and loved ones of the patient undergoing CPR are captured in a cataclysmic moment of hope, fear, anxiety, and shock as they wait to hear the outcome. The presence of an FF is a key component in FP that provides support to FMs and acts as the liaison between FMs and CPR team members (Meyers et al., 2004). In some institutions and situations, FMs and the FF are now included as members of the CPR team. “We need to realize that the most important part of that team is the patient and the family and include them” (Davidson et al., 2011, p. 341), and assure that space is made for the FM to be present with their loved one during CPR with a facilitator (Lowry, 2011; Meyers et al., 2004).

More healthcare institutions have recognized the benefits of FP and are more open to the practice of FPDR. Even though FP is becoming a more prevalent practice nationally, procedural implementation remains inconsistent. Practice varies in the following ways: (a) the point in the process when FMs are allowed to be with the patient (Eichhorn et al., 2001), (b) whether a person is designated to be with FMs, (c) who is chosen as the designated person (e.g., nurse, chaplain, or social worker), (d) the role of the FF, (e) availability of the FF (situationally dependent), and (f) when and if the CPR team leader and patient (if conscious) have to consent to FP (Hanson & Strawser, 1992; Lowry, 2011; Meyers et al., 2004).

The meaning associated with terminology is in question. FPDR indicates that FMs are in the room during resuscitation, but the practice of FP varies according to the situation. In some articles, the presence of a facilitator is evident; in others, it is unclear if a facilitator is present
with the FM. This proposed study will include the presence of an FF who remains with the FM throughout the resuscitation; therefore, the term FFPR will be used, indicating the presence of an FF. Many studies mention the presence of a facilitator and their role expectations, but the effect of the facilitator in the outcomes of the FMs’ experiences of FFPR remain relatively unknown. Similarly unknown are facilitator practices perceived by FMs as helpful or detrimental during the experience.

In emergencies requiring CPR, the option of FFPR is becoming an accepted norm in many healthcare facilities across the country. Despite the increased acceptance and practice of FFPR, implementation is inconsistent and the experience is not fully understood. Currently, no interpretive studies explored the long-term (3 or more months from event) experience of FFPR for FMs, nor do any studies explicate an FM’s experience of the facilitator during FFPR. As FFPR becomes standard practice during CPR, stakeholders need greater depth of understanding regarding the experience of facilitation in the practice of FFPR. The role of the facilitator needs clarification, education, guidance, and perhaps standardization. Ultimately, a need persists for continued exploration and understanding of the long-term effects of the experience of FFPR for FMs, to promote more effective and consistent practices.

**Purpose of the Study**

Being present during a highly emotional and stressful life-changing event such as FFPR is a very personal and delicate situation. Now that FPDR is a more accepted practice, the overall purpose of this study is to deepen understanding about FMs’ experiences of FFPR. One purpose of this study is to increase understanding of the long-term (3 or more months) perspective of FMs’ experiences of FFPR. An additional purpose of the study is to explicate FMs’ experiences of the FF during FFPR. Insight into how FMs experience FFPR and the role of the FF during
FFPR will aid in understanding and developing more effective facilitator practices and interventions.

Specific Aim and Research Question

What is the meaning of FMs’ experiences of FFPR of a loved one? This question was the overarching question for this study. Specific aims of this study included (a) generating an interpretation of FMs’ long-term (3 months or more following a CPR event) experience and meaning of being present with a loved one during resuscitation, (b) generating an interpretation of FMs’ experiences of the facilitator in the experience of FFPR, and (c) understanding FMs’ experiences and perspectives of current FFPR practices.

Significance of the Study

The death of a loved one or even the anticipated death of a loved one in a life-threatening situation can have life-long effects on a person’s mental and physical health (Tedrick Parikh & Wachter Morris, 2011). The effects of unresolved grief contribute to physical illness as well as to mental and emotional health challenges (Tedrick Parikh & Wachter Morris, 2011). Through increased understanding of what is meaningful for FMs during FFPR, nurses can be more effective in assisting families during resuscitation. Therefore, in gaining insight into the effects FFPR has on a person’s long-term grief process may aid in better understanding the phenomenon of being present during CPR on a loved one.

Feasibility Study

Initially, I designed and presented a feasibility study to the Washington State University and Spokane Institutional Review Board (IRB) for approval to determine whether people who experienced FFPR would willingly share their experiences, and whether study procedures were adequate to answer the research question. The proposal to conduct a philosophical hermeneutic
study of FMs who experienced FFPR at least 3 months prior to the interview, received human-subject-protection approval from the IRB. The intent was to obtain one to two interviews to refine the solicitation process and the interview format and analyze the transcripts for rudimentary themes. Further discussion of the feasibility study is included in the methods section in Chapter 3. At this time, more questions than answers surround the practice of FPDR and FFPR. Understanding more about the experiences of FMs present during resuscitation is important. The need for this study and its significance will become more apparent in the following literature review.
CHAPTER TWO

LITERATURE REVIEW

FFPR is a practice in healthcare facilities that is gaining in prevalence across the country. This integrated literature review highlights the development, key concepts, issues, and relevant theories related to FFPR and focuses on current knowledge regarding FMs’ experience of FFPR. Available literature includes a few studies from FMs’ perspectives regarding FMs being present with a patient during resuscitation. However, no studies focused on FMs’ experiences of the FF in the experience of FFPR.

For explicit clarification of the presence of a facilitator, in this study, I use the term FPDR when the presence of a facilitator is not specifically expressed or a facilitator is clearly not present. When the situation clearly identifies a facilitator being present with the family, the term used will be FFPR. This literature review will be an integrative literature review focusing primarily on the explicit practice of FFPR.

Sources for this integrated literature review came from a number of databases and include a variety of literature types. Literature for this review of FPDR/FFPR came from the databases of EBSCOhost, CINAHL, and PsycINFO using the following keywords: family presence, family presence during resuscitation, facilitated family presence, facilitated family presence during CPR, family witnessed resuscitation, CPR, cardiopulmonary resuscitation, trauma and CPR, emergencies and CPR, and psychological effects of FPDR. Literature searches referencing FPDR/FFPR revealed 85 relevant articles spanning publication dates between 1992 and 2015. Of the 85 articles, 41 were published between 2008 and 2010, reflecting a time of heightened conversation about FPDR/FFPR in healthcare.
Types of published articles include original research, literature reviews, personal experience, policy recommendations, and personal-opinion articles. Of the 85 articles, 37 were based on original research, including two seminal studies that were the impetus for beginning the conversation and initiating change of practice, allowing FMs to be present with adult patients during resuscitation. These two studies (Hanson & Strawser, 1992; Robinson et al., 1998) were the first and most widely referenced studies in literature reviews and subsequent research studies about FFPR. The literature about FPDR/FFPR included seven original research studies about FP in the pediatric population; seven interdisciplinary articles from physician, nurse, and staff perspectives of FPDR (three from countries outside the United States); nine from the nurses’ perspective (four from countries outside the United States); six on FM perspectives (two from countries outside the United States); three on patients’ perspectives (one from a country outside the United States); and two that included perspectives from patients, FMs, and health professional staff in the same study. The four remaining articles focused on implementation of FFPR policies and practices. Articles included in this literature review are primarily original-research articles that focused on FFPR in adult-care settings.

**Facilitated Family Presence during Resuscitation (FFPR)**

In the past 52 years, CPR has been the primary intervention for sudden cardiac and respiratory arrest. CPR is the initiation of external chest compressions and assisted respirations to promote circulation of blood and oxygen throughout the body when a person’s heart has ceased to function. With initiation of CPR and other technological interventions in a physiological medical crisis, FMs have traditionally been moved from the patient’s bedside and taken to another area away from the patient to wait for updates. Not only are FMs isolated from their
loved one and unaware of the patient’s status, the patient is surrounded by strangers. In many cases, these moments were the last time the FMs saw the patient alive.

For about 30 years, FPDR has been a controversial practice in the healthcare setting. Critical situations in which a person’s life wavers between life and death evoke a multitude of extreme emotions among FMs while waiting for news of a patient’s status. In the midst of such anxious moments, many FMs simply want to be with the patient to provide support (Hanson & Strawser, 1992). Some nurses advocate for FMs to be present by providing the opportunity for them to be at the patient’s bedside or nearby during situations requiring CPR. For example, up to 78% of intensive-care-unit nurses in adult critical-care units prefer unrestricted family visitation policies (AACN, 2011). The number of healthcare institutions across the country that have implemented policies supporting the practice of FPDR is increasing, but as many as 70% of hospital intensive-care-unit policies have restricted family visitation (AACN, 2011). Professional organizations such as the ENA, AACN, and the American Pediatrics Association support the practice of FPDR (Kingsnorth et al., 2010). These organizations have developed and published recommended FPDR practice guidelines (AACN, 2011). With the increase of patient-centered and family-centered-care approaches in healthcare, even medical associations such as the American Academy of Pediatrics and the American College of Emergency Physicians support the practice of FPDR (American College of Emergency Physicians Board of Directors, 2012). Despite recommendations supporting FPDR, resistance continues among nurses, physicians, other healthcare workers, and institutions in adopting family-presence policies and practices (Davidson et al., 2011). Among institutions where FPDR policies have been adopted, HCPs practice implementation inconsistently (Lowry, 2011; Twibell et al., 2008).
Acceptance of FPDR as common practice has increased in facilities where a FF is included as the normative protocol during the resuscitation event (Cottle & James, 2008; Davidson et al., 2011; Leske, McAndrew, & Brasel, 2013; Lowry, 2011). Guidelines for institutional adoption of FP highly recommend a facilitator be with the family throughout and following the resuscitation event. In 2005, the American College of Critical Care Medicine Task Force recognized the practice of FP at resuscitation as meaningful for families because it strengthens the bond between FMs and physicians, thereby decreasing risk of litigation. Resuscitation team leaders agree that a facilitator is important to FP at resuscitation (Leske et al., 2013). Recommendations for FFPR include development of a structured process, provision of a designated trained team member (chaplain, social worker, or nurse) to provide family support during resuscitation, and resuscitation team training that includes education on the process and rationale for FFPR (Davidson et al., 2007; Kingsnorth et al., 2010).

In spite of these recommendations, the facilitator’s role is the primary inconsistency in the emerging FPDR movement. The presence of a designated facilitator is not clearly stated or practiced in all facilities, nor is it evident in the description provided in many research studies. In one study, the practice of FPDR was discussed throughout the article, but the presence of a facilitator or family-support person was not explicitly stated until the end of the article. However, no articles provided a description of how the family experienced the role of the FF. A key to effective FP includes the supportive role of the FF (Clark et al., 2005; Cottle & James, 2008; Leske, 2013), however little is known about the supportive role of the facilitator from the point of view of the family.

In articles that do mention the FF, recommendations vary regarding topics such as selection by discipline, required skills, training, and roles following resuscitation. Many authors
recommend facilitators be chaplains, nurses, or social workers, who remain with the family throughout and following the resuscitation (Davidson et al., 2007; Hanson & Strawser, 1992; Kingsnorth et al., 2010; Sacred Heart Medical Center, 2000). Training recommendations for the position include assessing FMs’ suitability to be in the resuscitation room, identifying and managing escalating and potentially disruptive behaviors, understanding resuscitation procedures and response implications, and communication skills for difficult conversations. Some consensus exists that following resuscitation, it is helpful to families to facilitate good-byes and postmortem activities (Hanson & Strawser, 1992; Pasquale, Pasquale, Baga, Eid, & Leske., 2010). Likewise, following difficult or challenging resuscitation events, it is helpful to have the FF conduct debriefing sessions for the staff (Davidson et al., 2011).

**Historical Development**

HCPs have practiced CPR in a variety of ways since the 18th century, but modern versions of CPR were not authorized for use in hospitals until 1960. When HCPs adopted CPR as an approved intervention for sudden cardiac arrest, stakeholders hoped it would reverse and eliminate sudden cardiac death. A brief review of the historical development and practices of CPR follow in a discussion including CPR, technology and the deathbed ritual, survival rates of CPR, *slow code* practice, code status, and a safe place for FMs.

**CPR, Technology, and the Deathbed Ritual**

Throughout the 18th, 19th, and early 20th centuries, HCPs developed various forms of CPR to attempt resuscitation of people who had experienced sudden cardiac arrest, but the procedure was not officially adopted in the healthcare setting until 1960 (Tercier, 2002). Before 1960, FPDR was not an issue because CPR was not yet an approved intervention in cases of sudden cardiac arrest. If a person was ill, FMs cared for them at home or in the hospital,
providing comfort care and, if imminently dying, standing vigil until time of death. If the family involved an available physician, the physician visited the home. If there was a spiritual leader or an experienced FM, these persons acted as FFs in assisting the family with “death-bed” vigils (Kellehear, 2013; Tercier, 2002).

In 1960, hospitals introduced CPR as standard practice for sudden cardiac arrest with great hopes of saving many lives. However, as CPR and other invasive interventions were introduced, HCPs assumed these procedures were too traumatic for FMs to witness. Therefore, standard practice was to take FMs away from the patient’s bedside to a safe place. They received periodic updates about the patient’s status while being shielded from witnessing traumatic interventions. FMs waited in suspense while the medical team worked to resuscitate the patient. With the introduction of CPR as a standard of care, the person at the patient’s bedside at time of death was no longer the familiar face of a FM, but now was the face of a stranger (Tedrick Parikh & Wachter Morris, 2011; Tercier, 2002). In short, the setting of the deathbed transferred from the home to the institutional setting, from a familiar to an unknown environment, from family to strangers present at the time of death. Consequently, FMs were often prevented from being with the patient at time of death, changing the practice of family traditions at time of death, and affecting grieving rituals following death (Kellehear, 2013; Tercier, 2002). Because of the relocation of the deathbed scene, the media began to become the primary source for how death occurs, what it looks like, and how to handle death. Hence, the effectiveness of CPR has been glamorized in its portrayal of high success rates on popular medical shows ranging from a 42% to 64% success rate (Tercier, 2002). “CPR has become the medical, legal, and media standard of behavior in the face of sudden death” (p. 284).
Survival Rates

As CPR became an institutionalized practice, it became the primary intervention for cardiac arrest. With time, it became apparent that CPR was not as successful in saving lives as hoped and that it was not appropriate in all cases. Dismal survival rates frustrated HCPs because CPR did not yield anticipated survival outcomes. Between 1992 and 2005, in-hospital CPR rates of survival to discharge ranged from 7 to 26% with a mean survival rate of about 17% (Ehlenbach et al., 2009, p. 25). Factors contributing to lower rates of survival related to age, race, gender, and the presence of chronic illness. Patients who were over 65 years of age, of non-White heritage, or male with chronic conditions such as congestive heart failure, stroke, or diabetes had lower survival rates (Ehlenbach et al., 2009, p. 26). Even with improved technology, medications and increased knowledge, patients 65 years and older continued to have no significant improvement in survival rates (Ehlenbach et al., 2009, p. 30). Likewise, out-of-hospital-cardiac-arrest survival rates for the past 3 decades have remained between 6.7 and 8.4% from time of arrest to discharge. Overall in-hospital and out-of-hospital survival rates range between 4 and 18%, with no significant improvement over the past 30 years (Sasson, Rogers, Dahl, & Kellermann, 2010). Although certain procedural strategies improved immediate survival rates, minimal differences accrued in 30-day mortality rates. With such dismal survival rates, especially in cases where resuscitation was obviously futile but an obligation existed to respond to the cardiac arrest, the practice of a slow code was an unofficial response used to respond to cardiac arrest without a full response (DePalma, Ozanich, Miller, & Yancich, 1999).

Slow Code

A slow code is “a deliberate decision to not aggressively attempt to resuscitate a patient” (DePalma et al., 1999, p. 89). Patients in a poor state of health, with end-stage chronic health...
conditions, or in situations in which the resuscitation team knew that full resuscitation efforts would be futile are examples of situations in which a slow code occurred. Contributing factors to this practice were the tradition in health care to prolong life at all costs, physicians’ discomfort when discussing difficult outcomes and potential death with the patient and FMs, and an underlying philosophy of “doctor knows best” (DePalma et al., 1999).

Clarity in understanding the difference between “doing everything” and “doing everything that will help” is key in alleviating the need for a slow code. This is especially true when opposition arises from the medical team, the family, or the patient, to a Do Not Resuscitate (DNR) status; then initiation and cessation of CPR becomes complicated. Communication difficulties and the use of a slow-code breaches trust in the doctor–patient and doctor–family relationship, because physicians then must make decisions that may not be congruent with patient or family desires (DePalma et al., 1999). Slow codes are no longer acceptable practice and physicians must hold conversations with patients regarding their desires for interventions if they experience cardiac arrest. Every patient, upon admission to a hospital, should have a designated code status documented in his or her admission orders.

**Code Status**

A no code or a DNR order is a plan of care placed by a physician, nurse practitioner, or physician assistant based on an informed decision made by the patient, if able, or FMs following a discussion with the health professional. The DNR order gives direction to the healthcare team to withhold CPR and to withhold any resuscitative interventions in the case of cardiac arrest. If the patient is unable to provide input, the designated medical Durable Power of Attorney (DPOA) and the health professional discuss the patient’s prognosis and make a decision either to
initiate or to withhold CPR in the event of a future cardiac arrest. Terminology indicating a *no code* status includes no code or DNR, do not attempt resuscitation, or allow natural death.

People with a long-term chronic illness or a poor prognostic outcome usually have time to discuss their end-of-life desires with their HCP. Such discussions allow the patient or DPOA to specify their wishes regarding the initiation and cessation of life-prolonging interventions such as intravenous fluids and feeding, tube feeding, antibiotics, artificial resuscitation, cardiac compression, and defibrillation. In the case of a known terminal illness, patients establish advance directives before a person succumbs to an unresponsive condition. An advance directive, also referenced as a living will or a DPOA for Healthcare, is not always valid in emergencies (Washington State Medical Association, 2014a), nor is an advance directive a legal document. A document recognized by paramedics and emergency departments is a Physician Ordered Life Sustaining Treatment (POLST) form. A POLST form is portable among healthcare agencies. When a patient has a life-limiting illness, the physician and patient discuss end-of-life preferences, make decisions, and document preferred life-sustaining interventions on the POLST form in a streamlined easy-to-read format (Washington State Medical Association, 2014b). The patient then places the document in a prominent place in the home or the patient’s medical record in a healthcare institution. Currently, two states have mature programs, 17 states have endorsed the POLST form as an acceptable form to document end-of-life-preferences, 28 are developing implementation strategies, and three states do not use the POLST form (Physician Orders for Life-Sustaining Treatment Paradigm, 2012).

Although the literature encourages discussions regarding end-of-life preferences in advance of a life-threatening event, the decisions cannot comprehensively cover every possible scenario. In a study by Olver and Elliot (2008), even some patients with terminal cancer could
not give a definitive preference of whether to resuscitate. Hesitations regarding a DNR commitment are situationally based. Some viewed making a DNR commitment as a sign of giving up and letting the disease win; thus, they deferred to a medical decision when the time came. Others wanted the family to do what was best when the time came. Those in support of a DNR order commented that if they needed CPR, “not to start, because if they needed CPR, they were already dead” (Olver & Elliot, 2008, p. 349). Others thought CPR was something done after death and did not want medical resources used to “bring back the dead” (p. 349). Patients with good relationships with their physicians expressed comfort in knowing that their physician would do what was best for them. They also expressed concern about a physician who did not know them, believing they might not make the best decision due to a lack of knowledge of the patient (Olver & Elliot, 2008).

**Safe Place**

Safe-place practices reflect concerns and reasons for not allowing FMs to be present during resuscitation. HCPs cite four levels of protection as rationales for the safe-place practice. First is to protect the FM, based on assumption that FMs would not want to witness CPR or other traumatic interventions and would be unable to “handle” witnessing traumatic interventions (Meyers et al., 2004). In addition, HCPs have a concern that FMs may become highly emotional and exhibit disruptive behavior that may interfere with performance of medical interventions (Hanson & Strawser, 1992; Meyers et al., 2004).

The second reason for safe place practice is to protect the patient. Having FMs in a safe place allows private patient medical information to remain private. Some patients reported they do not want FMs to witness traumatic events; however, they reported that it was comforting having FMs at the bedside (Eichhorn et al., 2001).
The third reason for safe-place practices is to protect HCPs. FMs might perceive a mistake by an HCP or misunderstand what was said during the resuscitation. Less experienced HCPs may fear experiencing “stage fright” in front of FMs, thus potentially delaying the timing of critical interventions (Doolin, Quinn, Bryant, Lyons, & Kleinpell, 2010; Duran et al., 2007). Two studies that evaluated FM presence and procedural timing during CPR suggested this fear is unfounded, no delays occurred in critical interventions (Dudley et al., 2009; Pasquale et al., 2010).

The fourth reason cited for a safe-place practice was to protect the institution. Concern about increased risk for potential litigation was and continues to be a reason institutions use to restrict FMs from attending the patient at the bedside (Robinson et al., 1998). As of 2008, no litigation cases involved FFPR situations (Atwood, 2008). The comprehensive literature reviewed for this study included no mention of litigation related to FPDR/FFPR. In slow-code and safe-place situations, a lack of knowledge about the attempted interventions and about the patient’s response to the interventions led to mistrust between FMs and HCPs (DePalma et al., 1999; Meyers et al., 2004; Tercier, 2002).

**Landmark Cases**

When HCPs initiated a resuscitation event, taking FMs to a safe place was standard practice until a FM challenged this practice. In 1989, a patient’s spouse challenged the policy of taking FMs to a safe place away from the resuscitation event and demanded to be at the bedside of her loved one at Foote Hospital in Michigan (Hanson & Strawser, 1992; Robinson et al., 1998). This event was pivotal in the initiation of the discussion regarding the activities of FMs during a resuscitation event. A second landmark case following the introduction of FFPR took place in Addenbrooke Hospital in Cambridge, England.
In 1989, researchers provided a 9-year perspective of FPDR in Foote Hospital, significant because of its innovation and the development of a “planned participation program” (Hanson & Strawser, 1992). The program began in 1982, initiated by Chaplain Hank Post and a team of emergency-department physicians and nurses. The program incorporated FMs into the resuscitation process and treated them as expected members of the code team when accompanied by an FF. As part of the code team, the FF stayed with the FM throughout the process. A room was prepared for the family to stay during the event, the facilitator prepared the FM by explaining procedures, what to expect when entering the patient room, and instructions about being in the resuscitation area. The FF also used this time to evaluate the FMs’ mental and emotional state for appropriateness of being in the patient’s room during the resuscitation.

During the resuscitation, the FM was always accompanied by the FF and could come and go into the patient’s room as desired. Following the resuscitation event, FMs, along with the resuscitation team, participated in a postevent evaluation of the effectiveness of the resuscitation response (Hanson & Strawser, 1992).

The critical incident leading to the development of the program at Foote Hospital was the result of two separate incidents in which FMs demanded to be present with the patient undergoing invasive procedures and CPR. In these two situations, a change of practice occurred in the moment due to the FMs’ demands. FMs were allowed to stay with the patient and an FF (chaplain) was with the FM throughout the situation to support the FM. Following the event, the chaplain received feedback from the FM and staff about the experience and both parties reported it as a positive experience in facilitating the work of grief. As a result, the hospital created a comprehensive planned participation program, involving interdisciplinary team members, to offer FMs the opportunity to be present with their loved ones in the last moments of life when
CPR was implemented. FFPR has been routine in trauma situations and cardiac arrests in the emergency department at Foote Hospital since the early 1990s (Hanson & Strawser, 1992). Of the FMs surveyed, “47 returned the surveys and 76% felt that their adjustment to death was made easier by being present in the room and 64% felt their presence in the room was beneficial to the dying person” (Hanson & Strawser, 1992, p. 105). FMs found comfort in knowing what happened during the resuscitation, and being able to be present at their loved one’s time of the death (Robinson et al., 1998). Despite staff concerns that FMs’ physical or emotional disruption of the resuscitative efforts may delay the resuscitation process, FMs have rarely been disruptive during FFPR (Hanson & Strawser, 1992; Leske et al., 2013; Robinson et al., 1998).

Another concern inhibiting HCPs from allowing FMs to be present during resuscitation is that FMs would see a mistake or think a mistake was made, leading to litigation. Less experienced HCPs have expressed concern about potential performance anxiety, but functioned professionally and competently with no accusations of incompetent performance. Nurses reported they were able to support FMs of all ages in grieving and reported FFPR to be a “humanizing and workable experience” and “couldn’t imagine it any other way” (Hanson & Strawser, 1992, p. 106).

The second landmark study was published by Robinson et al. (1998) at Addenbrooke Hospital in the United Kingdom. The goal of the study was to determine if relatives wanted to be present during resuscitation and, if so, if any psychological effects manifested in bereaved relatives who had witnessed resuscitation of a loved one. Using a randomized comparative study, researchers evaluated the level of grief experienced between FMs present and FMs not present during resuscitation. FMs completed surveys at 1 month and 6 months following the event. The authors selected 25 patients, based on timing of admission to the emergency department, and
randomly assigned them to a group (13 patients in the witnessed resuscitation group, of which 3 patients lived and 12 patients in the control group, all patients died). Robinson et al. offered FMs in the experimental group FFPR, choosing one FM for each patient, usually the one who was most closely related. An FF was with the FM throughout and following the resuscitation. Afterward, researchers asked FMs to complete surveys about their experiences. The authors sent follow-up questionnaires at 1 month and 6 months post event to FMs of the patients who died and consented to participate, with an average return time of 3 and 9 months post event. Responses were received from all but four FMs, two from each group. The questionnaires included: (a) the Impact of Events Scale, which measures posttraumatic disturbance; (b) the Hospital Anxiety and Depression scale, which evaluates for significant anxiety and depression; (c) the Beck Depression Inventory, which assesses severity of depression; (d) the Beck Anxiety Inventory, which assesses the severity of anxiety; (e) the Texas Inventory of Grief (TRIG1) which evaluates grief after bereavement addressing feelings and actions at time of death; and TRIG2, which evaluates current feelings of grief and bereavement (Robinson et al., 1998).

Results from this study affirmed the benefits of FFPR even during the performance of invasive procedures (Robinson et al., 1998). This study protocol differed slightly from the Foote Hospital study because the FM was allowed to be present with the patient during intubation, intravascular cannulation, thoracentesis, and pericardiocentesis procedures, whereas at Foote Hospital these procedures were performed before the family entered the resuscitation room. However, no FM was frightened by the procedures or requested to leave during the invasive procedures: seven of eight felt their grief had been relieved by being present during their loved one’s last moments of life and all eight were at ease with their decision to be present. Overall, median scores for the two-group comparisons at 3 and 9 month surveys measuring anxiety,
depression, intrusive imagery, posttraumatic avoidance behavior, and grief were lower \((p = .73)\) for the FMs of the witnessed resuscitation group than those in the control group. The between-group comparison at 9 months showed that grief scores were lower in the witnessed resuscitation group and differences in TRIG2 scores were possibly clinically significant, although not statistically significant \((p = .084)\). The TRIG1 measured grief and the TRIG2 measured feelings (Robinson et al., 1998). Thus, no evidence emerged that excluding FMs during invasive procedures or resuscitation was in FMs’ better interests.

Staff at Foote and Addenbrooke Hospitals reported no interruptions from FMs during the resuscitation or invasive procedures, no criticisms from FMs on any procedural difficulties, and no delay or stoppage of CPR (Hanson & Strawser, 1992; Robinson et al., 1998). Staff reported benefits to having FMs present because patients were humanized and seen as valuable members of a family (Robinson et al., 1998). An additional benefit was the opportunity to develop a rapport with the FM before having to discuss unexpected news of a death (Robinson et al., 1998). FMs were able to provide helpful information about patients’ medical histories, medication use, and preferences at end-of-life (Hanson & Strawser, 1992). Due to the positive experience of FMs and staff, many became convinced of the benefits of FFPR and began offering it to all FMs of patients during resuscitation. Thus, the random-assignment plan of the study was compromised and the study ended, but the practice of FFPR continued (Robinson et al., 1998).

These two landmark cases, as well as subsequent studies, debunked myths and revealed insights regarding the benefits of family participation to patients, FMs, and the resuscitation team. Myths regarding increased risk for liability and litigation, breach of patient privacy, or long-term psychological trauma for the FM have not occurred. In the years since the publication
of these two studies, more healthcare institutions have adopted family-presence policies, however, inconsistencies exist among the facilities that practice FPDR/FFPR. Recommendations in the literature included developing a structured process, providing a designated team member trained to serve as the FF, and training the resuscitation team on how to incorporate FMs in the event and how to facilitate staff debriefing sessions (Davidson et al., 2007; Hanson & Strawser, 1992; Robinson et al., 1998).

**Supporting Research**

Most published research related to FPDR is based on scales that measured preferences or responses to survey questionnaires. Research supporting the practice of FPDR and FFPR include concepts related to the role of the FF, various perspectives of people involved in the resuscitation process such as FMs, patients, resuscitation team members, and healthcare administrators.

**Role of the Family Facilitator**

Key to the practice of FFPR is the role of the FF. In the landmark cases at Foote and Addenbrooke hospitals, the facilitator role was explicit in the practice and a designated member of the resuscitation team. Responsibilities included notifying the resuscitation team of the FMs’ arrival, obtaining permission from the resuscitation-team leader to bring the FM into the room, preparing a private room for the family to wait, updating FMs about the situation, and preparing them for what they will encounter when entering the patient’s room. While explaining to the family about the patient’s condition, the facilitator evaluates the family for appropriateness in the resuscitation room. Exclusion criteria included being under the age of 18, intoxicated, prone to emotional escalation, and, being a suspected abuser. When the FM was ready, the facilitator escorted the FM into the patient’s room, provided a place to stand, gave instructions and explanations, answered questions, provided opportunities to touch the patient, served as a liaison
between the resuscitation team and the patient’s FM, and accompanied the FM in and out of the room as the FM needed. In establishing this relationship with the FM, the facilitator was able to provide grief support and assist the FM with decisions on post-mortem care and disposition (AACN, 2011; Cottle & James, 2008; Doolin et al., 2010; ENA, 2005; Hanson & Strawser, 1992; Meyers et al., 2004; Robinson et al., 1998). The literature describing the responsibilities of FFs, was consistent with the previous description, reflecting the ENA position statement (2005) and AACN’s (2004, 2011) policy and practice recommendations.

Researchers also offered consistent recommendations for developing institutional policies on practice protocol and training for all persons serving in the facilitator role. Disciplines suggested as most appropriate for this role were nurses, chaplains (Hanson & Strawser, 1992), social workers (Davidson, et al., 2011; Kingsnorth et al., 2010; Robinson, et al., 1998), child-life specialists, physicians (Mangurten et al., 2005), volunteers, nursing students, and pharmacy students (Clark et al., 2005). Recommended training for an FF included therapeutic-communication strategies, family-assessment training, crisis-intervention training, and information on resuscitation interventions, terminology, and process (Cottle & James, 2008; Hanson & Strawser, 1992; Meyers et al., 2004). Professional organizations also recommended training for FFs (AACN, 2011; ENA, 2005).

Researchers provided little discussion on the effect of the facilitator’s presence. The primary benefit cited was that the facilitator provided relief for the resuscitation team so they could focus on the patient and did not have to be concerned about the well-being of the FM (Hanson & Strawser, 1992; Meyers et al., 2004; Lowry, 2011). In a Chicago hospital, the protocol included having an FF present with an FM during any code or invasive procedure (Lowry, 2011). The practice had become such a part of the care culture that nurses “stand in” as
FFs when a chaplain is unavailable, although nurses expressed preference for chaplains to fill that role because of their ability to provide spiritual and grief support for the FM (Lowry, 2011).

An advantage of having a nurse in the role of FF is that nurses understand the medical terminology and interventions (Cottle & James, 2008). Disadvantages of nurses in the FF role is the lack of confidence nurses have in addressing the spiritual care needs of the FM and the lack of time nurses have after the resuscitation to provide support for the FM. Chaplains have the time to support the family following resuscitation and can assist in the discussion regarding disposition of the remains (Cottle & James, 2008).

Research specifically regarding the effect of the FF role in support of the FM during resuscitation is lacking. The presence of the FF allows resuscitation-team members to focus on the patient without being concerned about the well-being of the FM during the resuscitation. I identified no research that directly studied FMs’ experiences of the FF during FFPR (Cottle & James, 2008).

**Perspectives of Family Members**

When FPDR was first introduced in 1982, providing FMs an opportunity to be with their loved one during resuscitation was not an option in healthcare. Since the 1990s, the opportunity for FP has become more of an option. The ENA (2005) and AACN (2011) issued recommendations regarding FP protocol. Researchers have explored the perspective of the FM regarding their experience of FPDR at Foote Hospital (Hanson & Strawser, 1992), Addenbrooke Hospital in the UK (Robinson et al., 1998), and Presbyterian and Parkland Health & Hospital systems of Dallas (Meyers et al., 2004). Each study reported similar findings and positive experiences by FMs. Recent studies continue to support the findings of earlier studies (Leske et al., 2013). The following paragraphs summarize the positive effects of this practice.
**Knowledge and understanding.** In moments of crisis, FMs report that knowing what is happening helps them understand the severity of the patient’s condition. The opportunity for the first-hand visual and verbal knowledge of interventions used and seeing the patient’s response helps the FM begin to process the reality of the situation (Hanson & Strawser, 1992). Being present also diminishes the angst of not knowing what is going on, wondering and imagining the worst. FMs report that what they imagined was worse than what happened in reality (Meyers et al., 2004; Robinson et al., 1998).

**Opportunity to participate.** Being present provided the FM the opportunity to feel helpful and to be able to do something, rather than merely wait and feel useless. FMs were able to touch, kiss, hug, comfort, pray, calm the patient, provide assurance for the patient, and focus on their role in comforting the patient rather than on the trauma situation itself (Leske et al., 2013; Meyers et al., 2004). FMs were a familiar face and presence for the patient. When it was apparent that the resuscitation was not successful, the FM could say good-bye before ending the resuscitation event (Hanson & Strawser, 1992; Meyers et al., 2004; Robinson et al., 1998).

**Advocate for the patient.** During resuscitation, the HCP may or may not have knowledge about the patient’s background, medical history, or preferences. Having an FM present who knows the details of the patient’s life can provide additional beneficial information in determining the most appropriate interventions. The FM can advocate for the patient in notifying the HCP of patient discomfort or patient preferences regarding end-of-life choices. For instance, having someone present with the patient’s best interests in mind, the FM can say, “That’s enough.” However, they also felt their presence encouraged the HCP to try harder and do all they could for the patient (Hanson & Strawser, 1992; Leske et al., 2013; Meyers et al., 2004; Robinson et al., 1998).
**Fulfillment of vows.** Spouses reported it was important for them to be with their loved one until the last breath was taken. Some spouses who were unable to be present reported feeling they had broken their vows “to love honor and cherish in sickness and in health.” Other FMs stated they felt it was their right and their obligation to be by the bedside of their loved one (Fanslow, 1983; Hanson & Strawser, 1992; Meyers et al., 2004; Robinson et al., 1998).

**Facilitation of grief.** The Foote Hospital staff surveyed 18 FMs of recently deceased patients to inquire whether they would have liked to be present during resuscitation; 72% responded they wished they could have been present. Later, FMs who were present reported that being present brought a sense of reality and closure (Hanson & Strawser, 1992). The researchers studying at Addenbrooke Hospital used a survey to evaluate the grief response of study participants at 1 month and 6 months post-resuscitation. Findings revealed that being present during resuscitation helped seven of the eight respondent FMs face the reality of their loved one’s death sooner than those who were not present. Consequently, FFPR promoted initiation of the grief process. Respondents present during resuscitation also reported being at peace, knowing that everything possible was done to help save their loved one’s life. All eight were content with their decision to be present for their loved one’s last moments (Robinson et al., 1998).

**Perspectives of the Patient**

Researchers who surveyed survivors of resuscitation reported they were comforted by having a familiar face present, knew that there was someone looking out for them, felt it was their right to have an FM present, and liked the option of having an FM with them during CPR or invasive procedures (Duran et al., 2007). In the first survey of patient preferences by Eichhorn et al. (2001), researchers interviewed nine patients who experienced CPR or invasive procedures about their experiences; seven themes emerged. Patients reported that having an FM present was
a source of comfort and they felt safer. FMs acted as advocates to get the patients’ needs met. Having an FM present made them feel more human to HCPs and helped the patient feel more connected to their family. Patients felt that FP is a right, that there is an inherent need to be together, and that being present brought comfort to the FM. Patients acknowledged that, in certain situations, FP may not be feasible (Eichhorn et al., 2001).

In a study conducted in a hospital in the United Kingdom, patients admitted to the emergency department completed a survey about their opinions regarding family-witnessed resuscitation. Participants were patients in the hospital who had one or more invasive procedures but had not had CPR. Patients expressed that having an FM present would be comforting to them, that having an advocate present would be helpful in the exchange of information, and that it would be helpful for the family to know that all possible help was proffered. Patients also expressed that having an FM present and being there in the end was important: being able to say good-bye and not being alone at the time of death was very important to them. Additionally, patients felt that patient care and professionalism of the healthcare team was better with the presence of an FM. One concern expressed by patients was the potential trauma to their FMs in witnessing invasive and traumatic procedures (Mcmahon-Parkes, Moule, Benger, & Albarran, 2009).

**Perspectives of Resuscitation-Team Members**

Members of the resuscitation team reported that having an FM present in the room during resuscitation reminded them of the patient’s humanity and of the patient’s role in life as spouse, parent, child, or sibling. Developing rapport with the FM before time of death helped resuscitation-team members be “more aware of family needs” (Bassler, 1999, p. 130) and eased communication about unexpected news of a loved one’s death. In spite of concerns that having
an FM present might slow performance of specific resuscitation interventions, results of two pediatric studies on resuscitation times and efficiency of performing procedures revealed that FP did not have any significant effect on completion of key components of resuscitation (Dudley et al., 2009, p. 783). Having the FM present provided a source to obtain current information about the patient’s medical status, needs, and medications. Despite concern about an FM in the resuscitation room, having an FF present with the FM eased the tension and concern over the well-being of the FM (Hanson & Strawser, 1992; Lowry, 2011). In one study, nurses wrote on the survey, that if a support person were present with the family, they would allow the FM to be present in the resuscitation room (Bassler, 1999).

**Perspectives of the Institution**

Institutional administrators’ and physicians’ greatest concern regarding FPDR was an increased risk of litigation, but to date, no litigation has occurred. Instead, researchers reported increased patient and family satisfaction with care received (Hanson & Strawser, 1992). In recent publications regarding FP, litigation concerns were not mentioned (Leske, et al., 2013; Lowry, 2011).

**Summary**

In summary, research findings support the practice of FFPR. As FFPR is increasingly implemented in practice, the likelihood increases that it will be considered standard practice (Lowry, 2011). In spite of the positive outcomes reported for patients, FMs, and staff, the option of FFPR is not universal in health care. Although the AACN, ENA, American Pediatrics Association, and American College of Emergency Physicians support the practice, some facilities continue to exclude FMs from the resuscitation area. Researchers have gathered perspectives of FMs, patients, nurses, and physicians, but research on FMs’ experiences of the
facilitator during FFPR and the FF perspective are two areas that lack research (Cottle & James, 2008).

**Theories**

Three theories closely related to the concept of FFPR are crisis theory (Tedrick Parikh & Wachter Morris, 2011), end-of-life decision-making theory (Davidson, et al., 2007), and a newly proposed theory of vigils for the dying (Kellehear, 2013). A theory is

an organized, coherent, and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole. It is a symbolic description of a reality that is discovered, or invented for describing, explaining, predicting, or prescribing responses, events, situations, conditions, or relationships (Meleis, 2007, p. 37).

Theories used in an integrative review simply support existing research and are not foundational to the development of the research study methodology or method. Comparing these three theories with the practice of FFPR provides a framework to explore the meaning and experience of FFPR.

**Crisis Theory**

In the early 1970s, emergency departments began to recognize needs of spouses who lost a mate in sudden-death situations. Fanslow (1983) referred to a study conducted in 1973 by Hampe that evaluated the needs of grieving spouses in sudden-death situations. Study findings identified six needs, primarily related to one of two categories. The first category concerned the spouses relationship with the dying person. For this person, the opportunity to see the patient after admission and before death, as well as the ability to comfort the patient was an important
part of the relationship, and separation from the patient increased the distress of the spouse (Fanslow, 1983).

The second category was related to the personal needs of the grieving person (Fanslow, 1983). Meeting the needs of the grieving person happened when the grieving person felt supported by HCPs, was updated about the patient’s status, and had the opportunity to share concerns about the patient. “Each element shapes the response of the bereaved … and each situation is unique” (Fanslow, 1983, p. 213). Beyond the immediate aspect of supporting the grieving person in the moment, consideration of the person and the patient’s unique cultural influences is critical in providing individualized family-centered care.

Crisis-intervention theory was used to help FMs cope (Fanslow, 1983). Results from Fanslow’s 1983 study that evaluated the effectiveness of crisis intervention for FMs 6 months after a sudden-death experience revealed that the only benefit of crisis intervention was in assisting FMs to make decisions as a family: “Crisis intervention alone did not affect the long term coping of sudden loss” (Fanslow, 1983, p. 214). Study findings confirmed that FMs are significantly impacted by the sudden death of a loved one, resulting in poor coping behavior and disturbed social functioning.

Spouses of patients experiencing a sudden-death situation expressed a need and desire to be with the patient before the actual time of death (Fanslow, 1983). Being present with the patient was important because the FM wanted to know (a) that all possible actions were taken, especially initiation of CPR, (b) the possibility of impending death of their spouse, and (c) about their spouse’s condition. Immediately upon death, spouses needed to have someone with them to explain the circumstances, and to hear them share their fears (Fanslow, 1983). HCPs frequently encounter patients in various levels of crisis who require the use of crisis-intervention skills
(Tedrick Parikh & Wachter Morris, 2011). The aforementioned studies are precursory discussions to the topic of FPDR/FFPR. Following, I compare crisis-intervention theory and the practice of FFPR.

Prior to a sudden crisis event, a person has an established community-support system and a way of functioning in that support system, usually consisting of FMs or close friends. When confronted with a crisis, defined as “a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms” (emphasis added; James, 2008, as cited in Tedrick Parikh & Wachter Morris, 2011, p. 369), a person’s response to a crisis event is usually reflective of their individual emotional and behavioral reactions. These “reactions evolve from personal and interpersonal resources, psychological states, and unconscious motivations for behavior, life roles, goals, values and tasks” (Tedrick Parikh & Wachter Morris, 2011, p. 369). Crisis theory can also apply to a family unit as an extension of the patient. Families, a community unit, have unique responses to crises: in the midst of a life and death event such as CPR, predicting how FMs will react is difficult. Therefore, having skilled professionals and procedures in place to assist FMs in managing a crisis event, such as that of FFPR, not only promotes better outcomes for managing the crisis event, but also promotes family/patient–centered care.

In crisis theory there is a “precipitating event” that initiates the need for a crisis intervention (emphasis added; Tedrick Parikh & Wachter Morris, 2011, p. 364). A goal of crisis theory is to “help people minimize or eliminate a bereavement crisis through helping them to learn how to mourn adequately and appropriately” (Tedrick Parikh & Wachter Morris, 2011, p. 364). For FMs experiencing the resuscitation of a loved one, the need for CPR is, in most situations, the precipitating event. The event is usually unexpected, unplanned, and the outcome
changes life for the patient and family forever. This moment can be labeled an event “of intolerable difficulty” with the experience being unique for each patient and family (emphasis added, Tedrick Parikh & Wachter Morris, 2011, p. 364). Management of the event is also unique to each situation, thus necessitating the need for crisis intervention.

Following the precipitating crisis event, the individual experiences disequilibrium, manifested by symptoms of exhaustion, feeling helpless feelings of inadequacy, confusion, physical symptoms, anxiety, and a reduction in functioning (Tedrick Parikh & Wachter Morris, 2011). These symptoms are similar to feelings FMs have reported when their loved one is undergoing resuscitation. When FMs do not have visual and verbal knowledge about the state of their loved one, their anxiety increases, they worry more about the outcome, and they describe the unknown waiting as agony (Robinson et al., 1998). FMs also express feeling helpless when not present with the patient, and that they want to be able to do something to help (Meyers et al., 2004). In contrast, FMs reported visual and verbal knowledge of the situation decreases worry, minimizes the agony of waiting, helps the FM understand and face the reality of the situation, and decreases their sense of helplessness (Meyers et al., 2004). Hence, being present assists in minimizing the angst of bereavement, a designated outcome of crisis theory.

Implementation of crisis-theory intervention requires the presence of trained personnel to facilitate the process. In FFPR, a facilitator is present with the primary purpose of easing the suffering of FMs by (a) helping FMs understand the rationale for and affects of the interventions, (b) advocating between FMs and the resuscitation team in making decisions, (c) promoting comfort of the patient in assisting FMs to be at the bedside, and (d) facilitating initiation of the grief process in the event of an unsuccessful resuscitation (Pasquale et al., 2010). In FFPR and
crisis theory, the desired result is to alleviate the crisis of bereavement. The *crisis intervention model* is a six-step model of crisis intervention that reflects the role of the FF.

The first phase in the crisis-intervention model, is the *listening phase*, which consists of three steps: (a) defining the problem, (b) ensuring client safety, and (c) providing support. The second phase is the *acting phase*, and consists of (d) examining alternatives, (e) making plans, and (f) obtaining commitment. In comparing the crisis-intervention model to recommended FFPR practices, the steps are similar.

During Step 1 of the listening phase, the goal is to define the problem. In FFPR the problem is evident in that a loved one has experienced a sudden cardiac arrest requiring CPR. Part of this step is clarifying the situation for the FM(s) and understanding the FM’s perception of the event. Step 2 is ensuring the safety of the patient and FM. In this step, the facilitator assesses the situation and acts to minimize any potential threats to the situation by evaluating the status of the FM(s) prior to escorting them to the bedside of the patient. In cases of suspected substance-influenced behavior, suspected physical abuse, escalating emotional reactions, or combative behavior, the facilitator will prevent or delay the presence of the FM(s) at the patient’s bedside to protect the patient and prevent distractions and disruptions for the resuscitation team (Doolin et al., 2010). The third step of the first phase is to provide support. In FFPR, the facilitator stays with FMs at the patient’s bedside. The facilitator’s role is to support FMs by preparing them for what they may see at the patient’s bedside, answer questions, serve as an advocate between the FM(s) and the resuscitation team, and remain with the FM(s) during and after the resuscitation event (Doolin et al., 2010; Hanson & Strawser, 1992; Robinson et al., 1998).
Next is the acting phase of the crisis-intervention model, which consists of *examining alternatives, making plans, and obtaining commitment* (Tedrick Parikh & Wachter Morris, 2011). Step 4, examining alternatives, involves exploring potential options. During FFPR, the facilitator explains and interprets the resuscitation interventions and the patient’s responses and helps the FM consider alternatives in making critical decisions. FMs have expressed relief in knowing what was happening, and in witnessing that all possible actions were performed to revive their loved one’s life. In the midst of the discussion about the patient’s status, the FM is involved in the conversation regarding known patient preferences, making decisions to continue pursuing further interventions, or stopping the resuscitation. Once it is apparent that resuscitation attempts are futile, the task of making decisions is eased by facing the reality of the situation and being present at the time of death. The FM then is able to move naturally into the next step of making plans.

Having the facilitator present with the family at the time of death allows for a natural progression into making post-mortem decisions and supporting the family (Cottle & James, 2008). Before the family leaves the hospital, the facilitator ensures that the family has a plan and the necessary contact information for the mortuary, understands the post-mortem plans, and is capable of implementing the plans. These activities fulfill the final step, obtaining commitment, of the crisis-intervention model (Tedrick Parikh & Wachter Morris, 2011). Crisis (intervention) theory parallels the practice of FFPR closely and provides a framework to support an FM through the experience of being with their loved one during resuscitation.

**End-of Life Decision-Making Theory**

Decision making in the healthcare setting has traditionally relied on two different models: a patient-autonomy model and a paternalistic model by physicians. However, in times of crisis,
the patient-autonomy model can be perceived as abandonment by the patient or FM if they do not have a full understanding of the situation when pressured to make a decision. When in a crisis situation, many prefer the physician to make the best decision possible in that moment (Davidson et al., 2007; Olver & Elliot, 2008). However, making decisions for persons who are cognitively incapacitated and unable to make their own decisions requires the input of a designated surrogate decision maker. In such situations, the process usually follows a standard bioethical process: a patient’s known wishes, interpreted patient wishes, patient’s best interest, and input from surrogate decision makers. However, a common difficulty in the process of trying to consider patient wishes is that many patients either have not discussed their end-of-life choices or simply prefer a designated surrogate and the physician to make any life-sustaining decisions (Berger, DeRenzo, & and Schwartz, 2008; Olver & Elliot, 2008).

**Traditional approaches to decision making.** Traditionally, decision making in end-of-life situations have been based primarily on the patient-autonomy model, surrogate model, or the paternalistic model. The autonomy model places the responsibility on the patient to make decisions about interventions upon being given an array of options from which to choose (Gillick, 2009, p. 122). The surrogate model places the decision-making responsibility on a designated other, if the patient is too cognitively incapacitated to make decisions (Berger et al., 2008, p. 48). In the paternalistic model, the physician is the authority figure who is responsible for making appropriate decisions. For instance, when the physician makes the decisions in a CPR event without including the family in the decision, lack of trust issues may result in the FM(s) questioning physician or HCP competency, whether all possible interventions were attempted, and if the patient suffered. Without full disclosure and understanding of the medical situation, these models are problematic in crisis situations (Davidson et al., 2007).
In a crisis event such as CPR, FMs struggle with initial feelings of confusion, anxiety, helplessness, disequilibrium, and exhaustion. If the surrogate or FM holds the ultimate responsibility for making decisions regarding life-prolonging interventions, without access to sufficient information, conversations with the healthcare team, or witnessing the event, many reported feelings of abandonment by the healthcare team (Davidson et al., 2007; Tedrick Parikh & Wachter Morris, 2011). Being overwhelmed by the crisis affects a person’s ability to cope and think clearly, causing decision making to be difficult (Tedrick Parikh & Wachter Morris, 2011). During a resuscitation event, FMs have expressed similar feelings, especially when they are not able to be with the patient and do not know what is happening. The lack of adequate information about the patient’s condition and situation not only contributes to a lack of knowledge, but also inhibits feeling connected to their loved one, making it difficult to make good decisions (Davidson et al., 2007; Meyers et al., 2004).

In contrast, in a crisis event, the physician and resuscitation team focus on continuous assessment of the patient’s physiological response to each intervention and determining the subsequent intervention, requiring timely decisions. Without a surrogate present to contribute to life-prolonging decisions, the physician is responsible for making decisions based on the paternalistic model. A shared decision-making model is a preferred model in making life-concerning health decisions (Davidson et al., 2007).

**Shared decision-making model.** The shared decision-making model is based on a partnership between the healthcare team, the patient, if able to contribute to the decision-making process, and the patient’s family or designated surrogate decision maker. Shared decision making is a primary component of patient/family-centered care. In this model, FMs can share patient and family preferences with the healthcare team and the healthcare team can share their assessments,
treatment recommendations, and patient response with the family. Both parties consider this information to make the best decision for the patient (Davidson et al., 2007). FFPR is an ideal situation for shared-decision making. FMs in the room during CPR are able to see and hear what is happening, thereby minimizing the need for some explanation. When decisions need to be made concerning the level of aggressive treatment, FM/surrogate and physician can discuss in “real-time” the possible options and arrive at consensus (Davidson et al., 2007).

**Experiential evidence.** When faced with a life-and-death issue in which a life-defining decision must be made, the critical factors of the decision include processing experiential evidence (Ziebland & Herxheimer, 2008) and progressing through a series of domains (personal, environmental, and decisional) to arrive at a final conclusion (Limerick, 2007). Experiential evidence is how people use the “personal experiences and the stories of others’ experiences in the process of making healthcare decisions” (Ziebland & Herxheimer, 2008, p. 433). Making decisions based on experiential evidence includes one’s personal experiences, stories about others’ experiences from those in a similar situation, clinical evidence and advice from HCPs, advice from an FM or friend who is a healthcare provider, and personal recommendations from the physician. To make a well-informed decision, the decision maker needs context, advice, and facts (Ziebland & Herxheimer, 2008).

**Domains.** In addition to the sources of information in making a decision, the decision maker also progresses through three domains in reaching a conclusion: personal, environmental, and decisions domains (Limerick, 2007). Each domain is unique but intertwining and iterative throughout the decision-making process. Although Limerick (2007) specifically related these three decision-making domains to experiences in an intensive-care-unit setting, one can experience these three domains in the decision-making process of FFPR.
First, the personal domain of decision making includes the decision maker seeking input from experts and support from family in evaluating the patient’s past and present condition, and considering the patient’s past and projected future quality of life (Limerick, 2007). In the environment domain, the actors develop relationships and establish rapport among healthcare providers, patients, and families in the hospital setting. It is in this relationship where trust is developed so that when the difficult decisions need to be made, the surrogate can trust the HCPs to provide true and honest information towards making an informed decision (Limerick, 2007).

In the decision domain, the decision maker comes to a new realization, also referenced as “arriving at a new belief” (Limerick, 2007, p. 336), about the futility of the situation. Once the reality of the situation is apparent, the decision maker then takes time alone to contemplate the options and determine the most appropriate choice. Surrogate decision makers have reported “experiencing an altered sense of reality upon realizing that the decision needed to be made” (Limerick, 2007, p. 335). Time alone differs for each person: some people are able to achieve alone time and space in their head, whereas others must have actual physical space to get the alone time they need to make the decision. After making the decision, the decision maker then communicates the decision to family and HCPs. Understanding the process and the information needed by a patient surrogate decision maker can be beneficial for HCPs in providing information and support for the process in a time-appropriate manner (Limerick, 2007).

In the context of FFPR, the decision-making process must accelerate and the personal and environmental domains occur simultaneously throughout the resuscitation process. However, if the patient was already admitted to the hospital before the resuscitation, the initial work in establishing a relationship and rapport has already been initiated. The personal domain is initiated at the onset of the need for resuscitation by the patient and when the FM becomes aware
of the patient’s status. This personal domain is present throughout the remainder of the resuscitation.

Initiation of the environment domain begins with summoning the code response team. In the context of FFPR, sometimes, initiation of the environment domain occurs before the family is aware of the patient’s condition, unless the patient has been in a declining state. During the resuscitation event, the physician can explain patient responses to the interventions, make recommendations, and ask questions of the FM about known patient preferences. The FF is present with the FM to answer questions, interpret events, and assist in discussing options and potential outcomes.

As soon as it is apparent the resuscitation efforts will not be successful, or the implications of a successful resuscitation need to be discussed, the FM enters the personal domain to consider options. At this time, the FM may need to remain with the patient or may need to take some time and physical space to consider options. The FF can assist the FM in taking time and physical space away from the situation by offering the FM the option to stay or to leave the room. Once the decision maker has made their decision, it is communicated to the HCPs and extended family. In recognizing the progression of FM’s decisional domain, the FF can provide a more effectual and opportunistic facilitation of the FFPR experience.

**Vigils for the Dying Theory**

Kellehear (2013) explored “why people do what they do for the needs of the dying” (p. 110). As U.S. culture has transferred the common place of death from home to an institutionalized setting, and the traditional vigil and wake for the dead has mostly disappeared, Kellehear proposed a new theory of vigils for the dying. A traditional vigil for the dying was the practice of waiting at the bedside of a dying person for the time of death. Once death was
thought to have happened, the “wake” ensued as a time of “standing watch over the dead” to protect and provide the opportunity for the dead to rise if they were not truly dead. Likewise, Tercier (2002) discussed how “the institutionalization of the deathbed has changed the bedside vigil, from a familiar setting to an unfamiliar and strange place” (p. 303). With this change in culture, the once practiced bedside vigil in the home has faded, and recent generations have not experienced traditional practices of bedside vigils at home or in a healthcare setting. Consequently, many do not know what to do in anticipation of death of a loved one, nor how to mourn following death of a loved one (Kellehear, 2013; Tercier, 2002). Likewise, healthcare providers and staff have little or no experience with deathbed vigils and are limited in knowledge of how to help patients and FMs during the dying process (Kellehear, 2013). Additionally, many healthcare providers express discomfort in knowing what to do or say when a patient is dying or has died (Meyers et al., 2004). Due to increased technology use and scientific advances, CPR has become an accepted practice and cultural expectation in instances of sudden cardiac arrest that led Kellehear and Tercier to suggest CPR has become part of the “new deathbed ritual.”

The vigil-of-the-dying theory describes activities associated with a deathbed vigil, and explains the purpose and meaning of a deathbed ritual (Kellehear, 2013). Kellehear (2013) suggested that functions of the wake include (a) establishing that death has happened, known as the death watch, (b) protecting the dying from evil spirits, (c) supporting and placating the dying person’s soul on its journey, (d) managing the inner turmoil of emotions for the dying person’s family, and (e) “opportunities to express dissent and resistance to civil or clerical control” (p. 121). The practice of FFPR correlates well with the suggested functions of the death-bed vigil.
**Functions of the death-bed vigil.** A modern vigil for the dying is a social phenomenon reflective of traditional practices of a wake for the deceased. The modern vigil establishes the reality of death of the dying: to protect and advocate for the dying and to have some control in the dying and death process. Whereas the purpose of the traditional wake for the dead focused on the postmortem activities of mourning and funeral planning, the “modern deathbed vigil might be seen as a persistent remnant tradition of the wake” (Kellehear, 2013, p. 112).

**Establishing death.** Traditionally, when anticipating the death of a loved one, family and friends would gather and “stand watch” over the dying: the death watch (Kellehear, 2013; Tercier, 2002). A death watch begins when it is determined the patient is in the dying process, now usually determined by an HCP and usually in a healthcare setting (Kellehear, 2013). Likewise, activities of the modern vigil are similar to the traditional bedside vigil in being with the dying person. “Family members sit by the bedside holding hands, storytelling and reminiscing, comforting, praying, laughing and crying” (Kellehear, 2013, p. 114). Within the historical Judeo-Christian culture, traditional death watches lasted approximately 3 days, provided an opportunity for the dead to revive themselves, if they wanted. It was a time to ensure that the dead person was really dead. Modern vigils may include CPR as an intervention with this same hope of revival, for if there is any chance of survival, CPR is the last resort and hope for evading death (Kellehear, 2013).

**Protective watchfulness.** Components of the vigil theory include gathering of family and friends, assigned different roles and responsibilities, transitioning life roles. When family gathers at times of impending death, Kellehear (2013) labeled this protective watchfulness, which includes being with, touching, telling stories and reminiscing, comforting the patient, holding, kissing, praying for the patient, and giving permission to die (Kellehear, 2013). This
aspect of the vigil theory reflects FFPR and the activities of the FM when present in the room during CPR. Being present enabled FMs to feel helpful to the patient, providing comfort and protection for the patient while in pain, afraid, vulnerable, and defenseless. FMs also have a great need for vigilance, which increases in crisis situations, and find it helpful to have someone present to explain what is happening (Wagner, 2004, p. 419). In studies, protective activities by FMs included identifying when the patient was in pain, providing information about the patient, interpreting the patient’s needs, signing documents, and acting as the family spokesperson in relaying information to other FMs (Duran et al., 2007). Additionally, participating in the process empowered the FM to feel valued as a helpful contributor to the resuscitation event (Wagner, 2004). Moreover, the FM and patient experienced a reciprocal presence, sharing a connection and bonding by being with each other. First-hand visual and verbal knowledge of last moments of their loved one’s life increased FMs’ understanding and decreased their worry, which decreased the agony of waiting (Meyers et al. 2004).

For the remaining FM, it is helpful to have a separate private room for their vigil (Hanson & Strawser, 1992). Although they may not be present with the patient, they can still be present in sharing stories while waiting for news about the patient. Reminiscing and planning can occur in the privacy of their space during this time (Meyers et al. 2004).

**Support for the dying person’s soul.** Being present at time of death is an important moment for families. This moment initiates new pathways for the one who has died and for the family. For the person who has died, it begins a journey that is culturally and religiously influenced regarding their beliefs about what happens beyond death. Traditionally, in some belief systems, this has been a time of supporting and placating the departing soul and sending them on their journey. For some, FMs pray for the deceased; others sprinkle holy water, some have a
feast, providing food and weapons for the departed to take on a spiritual journey (Kellehear, 2013).

**Management of inner turmoil and emotions.** Awareness of the reality that death has occurred is a highly emotional moment. This aspect of the vigil-for-the-dying theory incorporates the beginning stages of the wake for the dead and allows the emotional expression of the inner turmoil to be experienced. Following completion of the precipitating event, the crisis is not over: subsequent effects persist and are evidenced by a more global reduction in functioning, also described as a numb feeling, where usual coping mechanisms are now inadequate. This state of turmoil can last 4 to 6 weeks following the event, which is an optimal time frame for interventions to help the person resolve the effects of the crisis. This type of crisis differs from everyday life stress in that it can result in adaptive or maladaptive behaviors and consequences (Tedrick Parikh & Wachter Morris, 2011). Some postevent effects of FMs who were not allowed to be present with their loved one during resuscitation were delays in the grieving process and continuing questions, wondering if all possible actions had been taken for their loved one (Hanson & Strawser, 1992; Robinson et al., 1998; Lowry, 2011; Meyers et al. 2004).

**Resistance to control by others.** This concept comes from traditions when the civil or clerical authorities controlled many aspects of a person’s existence. The wake was a time that civil or religious laws did not apply, and the grieving indulged in excesses. In the modern concept of vigil, being intoxicated with any substance is unacceptable while in the healthcare facility, but happens (Kellehear, 2013). During FFPR, if the FM is intoxicated or highly emotional, they are not allowed to be in the resuscitation room. These five basic functions of a deathbed vigil can apply to the practice of FFPR. In recognizing these behavioral needs of FMs
anticipating the loss of a loved one during CPR, the FF can help facilitate activities throughout the resuscitation event.

**Rites of passage.** Rites of passage are components of the deathbed vigil that occur in anticipation of death and upon death of the dying person. The process ranges from expectantly waiting for death to the moment of death itself, and after death to the funeral or memorial services, partitioned into four rites. The rite of passage begins at the moment of death when rituals to send off the dead are initiated. The rite of separation is primarily a rite for the survivors, and begins before the time of death, when it is obvious the person is dying. At this point, both the dying and the family separate from their usual social roles in life. FMs leave their usual daily life routine to be with the dying person. A space is usually designated for the dying and another area arranged for the family in which physical movement back and forth by the family allows for a psychological, emotional, and spiritual preparation for death. This is a time for purification rituals, saying good-bye to loved ones, soothing the dying by giving them permission to leave, and giving assurance that the survivors will be alright. The rite of transition is for the survivors/mourners. This is the time for eating, drinking, storytelling, sharing memories of the dead, and performing rituals for the dead. The fourth and final rite, the rite of incorporation, is the funeral, memorial, and gatherings commemorating the dead, also known as a wake. A wake is a sendoff, a farewell to the dead (Kellehear, 2013).

Wake and vigil activities reflect known benefits of being present with a loved one during a resuscitation event. Research continues to reveal FFPR as beneficial for FMs in the grief process. “Reuniting FMs with the patient reconnects the act of dying with the act of mourning” (Tercier, 2002, p. 317). Initiation of the grief process begins with witnessing the events of the resuscitation, understanding the outcomes of the interventions, and being present at the moment
of death, thereby promoting earlier acceptance of the patient’s death. Being present provides the opportunity for closure of a shared life in order to treasure last moments together, to complete unfinished business, and to say good-bye. FMs have also reported this moment “to be a spiritual experience . . . [and] intuitively knew the point at which death occurred” (Meyers et al. 2004, p. 68). Having these experiences facilitated the grieving process and helped promote adequate and sufficient grieving (Meyers et al., 2004).

**Conclusion**

In conclusion, sufficient evidence supports the practice of FFPR and many authors reinforced the benefits for FMs, which resulted in greater acceptance and practice of FFPR in the clinical setting. Despite a number of studies supporting the practice from a patient and FM perspective and from nurses and HCPs, no retrospective studies addressed FMs’ experiences. Although studies support the practice of FFPR, a gap persists in understanding the meaning of the experience of facilitation for the FM. Further explication and interpretation of FMs’ experiences of FFPR would inform this practice.
CHAPTER THREE

METHODOLOGY

Philosophical Hermeneutics

Philosophical hermeneutics is a qualitative research approach grounded in Heideggerian and Gadamerian philosophies. The goal is to understand the lived experience of another and the meaning derived from the event. The crucial elements of temporality, language, and being distinguish philosophical hermeneutic research in communicating meaning of an experience (Gadamer, 1976). Philosophical hermeneutics is a research approach based on a “philosophy of understanding” not “an art of understanding” (Diekelmann, 2005, p. 21), “that comes through a communicative act or public self-disclosure about the event” (Arnett, 2007, p. 31). Interpretive methods of research are gaining recognition as valuable and useful in contributing knowledge to the practice of nursing. Prominent nursing researchers such as Diekelmann, Ironside, Benner, and Tanner have used interpretive inquiry to highlight the educational development of nurses, as they become experts in practice.

A misconception of interpretive inquiry is that the findings are subjective renditions of one person’s interpretation. Rather, interpretive inquiry is the coalescence of similar experience stories from multiple sources to elicit deeper understanding from, and to reveal meaning associated with, an event. Hence, “interpretive inquiry” is not “just subjective inquiry” (p. 31) “but a qualitative engagement of a given communicative event” (p. 32) resulting in the “offering of interpretive insight” (Arnett, 2007, p. 34).

Essential to the work of philosophical hermeneutics is an in-depth understanding of Heidegger’s philosophy. Intricate understanding promotes an array of possible uses and “provides a framework for investigating meaning of individuals’ experiences within the context
of their lives” (Johnson, 2000, p. 138). Hence, the situation, context, and purpose of the research will determine the selection of the appropriate interpretive research method and appropriate philosophical foundation (Vandermause & Fleming, 2011). In promoting patient and family-centered care in nursing, Heideggerian hermeneutic research can provide deeper understanding of patient and family experiences in the healthcare setting. Therefore, I used a philosophical hermeneutic method of research to explicate FMs’ experiences of FFPR. This study provided additional investigation of FMs’ experiences of FFPR from a perspective of at least 3-months post-event and FMs’ experience of the facilitator during resuscitation. Findings may help HCPs understand the lived experiences of study participants and eventually promote a more effective and meaningful experience for the family and patient.

**Philosophical Background**

Philosophical hermeneutics as a method of research derived its origins from a turning away from empirical observation and rational logic as the only way of knowing, to including subjective experience based in the context of time, person, and situation, as a valid source of knowledge (Willis, 2007). Before the Enlightenment, authority sources dispensed knowledge such as the church, secular rulers, sacred writings, or philosophers. The practice of empirical observation, also called the scientific process—one hallmark of the Enlightenment—was the primary source for generating new knowledge. As empirical, scientific disciplines such as chemistry, biology, and physics emerged as sources of knowledge and truth, the social sciences, such as psychology, sociology and anthropology, also developed scientific applications to advance knowledge. Psychology focused on experimentation in a scientific approach in order to be perceived as real science (Willis, 2007). By the late 19th century, the social sciences claimed a positivist position of a “neutral, objective, value-free process, separating the cognitive about an
object from the object itself in order to discover reality and find causes of social phenomena” (Willis, 2007, p. 43). German philosophers, however, began a new era of interpretivism, advancing through Dilthey, Husserl, Heidegger, and Gadamer, advising that an empirical approach to knowledge was not the only source of knowledge.

**Phase I: Dilthey**

Interpretivists among the social scientists, such as Wilhelm Dilthey (1833–1911), were not satisfied with the positivist approach and believed the social sciences were excessively scientific. Interpretivists’ foundational argument lay in two primary ideas: (a) “the idea that empiricism or ‘the experience of the senses’ (objectivism) is not always the best way to know something,” so the way to “come to reality is through thinking and reflecting about it” (rationalism); and (b) “what we perceive is always conditioned by our experiences and our culture” (relativism) (Willis, 2007, pp. 48–49). Dilthey rejected the argument of objectivism, proposing “a subjective base for social science” (Willis, 2007, p. 52), and “redefined hermeneutics as a science of historical understanding and sought a method for deriving objectively valid interpretations” (Ironside, 2011, p. 221).

Dilthey rejected the “sterile objectivism” of empirical science as the only form of true knowledge and proposed that true understanding only occurs contextually, in a holistic rather than atomistic process, and therefore, cannot be separated from one’s mental or conscious activities. Ultimately, for true knowledge to occur, “we must think in order to know reality” (Willis, 2007, pp. 52–53). Dilthey rejected and broke from empirical science because the purpose of social science is to understand, and understanding cannot come from law-like empirical generalizations, but from historical and contemporary situatedness of understanding. Therefore, phenomenology focuses on subjectivity, relativity of reality, and how humans understand and
view themselves in the world around them. Phenomenologists redefined and distinguished phenomena “as the perceptions or appearances from the human point of view” (Willis, 2007, p. 53).

**Phase II: Husserl and Heidegger**

During this era, Edmund Husserl introduced philosophy into the interpretivism of social science research with his first writing in 1907 of The Idea of Phenomenology. Husserl was the first, followed by a student, Martin Heidegger, in the 1927 publication of Being and Time (Gadamer, 1976). Even though Husserl and Heidegger viewed interpretivism through the lens of philosophy, their perspectives differed: whereas Husserl focused on description and explanation of lived experience, Heidegger interpreted lived experience as a search for a deeper understanding of the meaning associated with the experience (Willis, 2007).

**Husserl.** Edmund Husserl (1859–1938), a German mathematician and philosopher, developed interpretivism further. As one of the first to move away from the positivist approach, the intent was to develop a scientific approach to yielding objective knowledge from a subjective experience. Husserl sought to “establish philosophy as a rigorous science” (Gadamer, 1976, p. 215). To reveal the “truth in the lived experience,” Husserl maintained the researcher must suspend any personal beliefs about the research phenomena, and approach the phenomena without bias, known as *bracketing* or “phenomenological reduction” (McConnell-Henry, Champman, & Francis, 2009). The primary focus was to obtain empirical evidence to explain a phenomenon; therefore, the outcome is a description or explanation of the lived experience, not an interpretation.

**Heidegger.** Martin Heidegger (1889–1976), a student of Husserl, branched off from Husserl’s approach to phenomenology of describing lived experience. Heidegger introduced
interpretation of meaning into understanding one’s lived experience, thereby developing a philosophical hermeneutical method (Vandermause & Fleming, 2011). Heidegger did not believe it was possible to bracket oneself from the research process, because the researcher brings personal history and experiences to the interview and interpretive experience. However, Heidegger did promote awareness of one’s own biases and prejudices throughout the entire process, including the interview and interpretation (Gadamer, 1976).

Heidegger’s major focus was to seek understanding of another’s experience in the world, not explanation or description, but interpretation of one’s experience of a particular situation to understand the meaning of the experience for that person. Heidegger’s approach considered the context of the experience, based on the three-fold elements of time (past, present, and future), the language used to describe the situation, and the two-fold presence of being as factors in understanding the experience (Gadamer, 1976; Willis, 2007). The next section includes a more detailed explication of Heidegger’s philosophical underpinnings.

**Phase III: Gadamer**

Hans-Georg Gadamer (1900–2002), a student of Heidegger, reiterated that the goal of interpretivist research is not to find truth, but to search for understanding of a particular situation in context. Gadamer further developed Heidegger’s perspective of time, language, and being in interpretive understanding, through “immersing ourselves in the context we want to understand and by bringing to bear on our efforts all our past experiences and knowledge” (Willis, 2007, p. 189). Gadamer recommended researchers bring their experiences to the research process because the researchers’ experiences may be key to enhancing understanding. Hence, presuppositions, prejudices, and prejudices are considered, “the constantly operating unnoticed thinking” (Vandermause, 2008, p. 70) that we bring to a situation as part of the
understanding process. The prejudice becomes noticed only when it is provoked (Vandermause, 2008; Willis, 2007). Gadamer stated that one’s “prejudices are biases of our openness to the world. They are simply conditions whereby we experience something—whereby what we encounter says something to us” (Gadamer, 1976, p. 9). In that moment, one has already developed their interpretation of meaning toward an experience and must be aware of their own bias; this moment is referenced as “the provoking moment” (Gadamer, 1976, p. 9; Willis, 2007).

Gadamer (1976) further developed Heidegger’s concepts of time and being into the concept of the “fusion of horizons.” This means that “every transmission of meaning” is the result of the interpreter’s “horizon” transforming their view of the past from a “passive object of investigation” into multiple options for meaning (Gadamer, 1976, p. xix). This language assists in understanding Heidegger’s thoughts on the past meeting the future. Throughout the interview, the known interacts with the unknown, resulting in a “dynamic interplay” of time, situation, context, and language from the participant’s perspective of the experience and the researcher’s inquiry (Vandermause, 2008, p. 71). Gadamer reiterated that the goal of interpretive research is not a search for truth but a search for deeper understanding.

**Key Methodological Terminology**

Foundational philosophical concepts for philosophical hermeneutics are concepts relating to time, language, dialogue, being, and understanding. These concepts do not function in isolation and are not static, but dynamically interact with and affect the other concepts continually. A primary focus of Heidegger’s philosophy is the concept of “Being” and “being,” where “Being” refers to how human beings relate to or understand themselves in a situation, and “being” refers to the components of life that remain unchanged from situation to situation (Heidegger, 1959/1971). A distinctive quality of Heidegger’s manner of expressing fluidity
among concepts is the use of hyphens, used to distinguish between separate concepts that fuse together, thereby creating one concept. For instance, in the literary hyphenated depiction of Being-in-the-world, it is clear that Being and world cannot be separated, even though they represent two different ideas (McConnell-Henry et al., 2009). The experience involves facets of life in which one cannot exist without the other.

Dasein is another term used to reference human existence. It refers to how humans beings show up, relate in the world, and regard their own existence. It is not a spatial position of a person in the world, but a manner in which humans manifest themselves in a particular situation as a whole phenomenon. It is self-engagement in the process of understanding one’s experience of a situation (Grondin, 1994); “Dasein is a mode of being” (Gadamer, 1976, p. 125).

Language is another foundational concept for Heidegger. Language is “I-less” (Gadamer, 1976, p. 65). Being cannot exist in and of itself; “being” cannot be expressed or understood without language. Language is the mode in which beings are able to communicate meaning to another. To gain understanding, an “other” must exist and the “other” must speak the same language. Surprises are the thoughts and ideas revealed that one did not expect to be present; “for the reality of what we call language will bring us a surprise such as we dare not hope for even now” (Heidegger, 1959/1971, p. 27). Speaking is the representation of language. It is “one form of human activity that pertains to what comes as presence” (Heidegger, 1977/2008, p. 402).

“House of being” is a term developed by Gadamer that reflects Heidegger’s philosophy of language (Gadamer, 1976, p. 208). Language provides a framework or structure that provides a means of understanding “being.” This is not a metaphysical representation of a person’s body or place, but intended to indicate the “presence of being” or the “presence of the two-fold Being and being” (Heidegger 1959/1971, p. 26). These concepts apply to the interview process as
dialogue rather than a list of questions seeking knowledge, becoming “the trail of language” in which the listener attends. As the speaker speaks, the speaking gives presence to the speaker’s own “being.” Heidegger refers to this as “presencing”; the listener listens for their speech, listening for that which they linger on in any given situation, because that is what matters to them (Heidegger, 1977/2008). The dialogue is a time of listening, reflecting, responding, and inquiring in response to what the speaker revealed. In this reflexive process between two people, the interview is a dialogue that flows back and forth between two beings. In the midst of the dialogue, the moment of understanding is the point at which the thoughts of two beings are as one.

A key component of philosophical hermeneutics is the “temporal” aspect of Being; temporal means “being in time” (Heidegger, 1977/2008, p. 61). Time is relative in being, in speech, in language, and in thought. “Time is brought to light and genuinely grasped, as the horizon of every understanding and interpretation of Being” (Heidegger, 1977/2008, p. 60). In that moment of understanding in which meaning is conveyed, Being and time converge as past meeting the future in the present. This is what Gadamer termed the “fusion of horizons” (Gadamer, 1976, p. xix). The past is always passing as the future arrives, thus the perpetual coming and going of time affects one’s experience and understandings of a situation.

Verstehen, the German word for “understanding,” is a major focus in Heideggerian phenomenology. Understanding comes through language, being in dialogue, being present with, in reflection, and in seeking revealed meaning. In hermeneutics, understanding is interpretation. Interpretation has a three-fold structure: (a) the “fore-structure” or “fore-having”; the premise that all interpretations are based on familiarity with the phenomena, (b) “fore-sight,” the interpretive lens that forms our perspective in understanding, and (c) “fore-conception,” the

Last, is the term “hermeneutic circle.” The hermeneutic circle is fundamental to interpretive work. It is a process of interpretation, which is reflexive, reflective, and iterative. It moves from the particular to the whole and back to the particular to gain greater understanding. It involves a team of researchers participating in the interpretive process. Interpretation comes not only from dialogue with the participant, and the transcript of the dialogue, but also from dialogue among the interpreters. The team explores themes and patterns, looks for what is present in the text and what is absent from the text, and compares themes among texts for similarities and contradictions (Diekelmann & Magnussen Ironside, 2006; Willis, 2007).

Key terms such as Being, being, time, language, and understanding reflect critical concepts in philosophical hermeneutics. These concepts guide and influence the entire research process, from developing the plan for research, to the implementation and participation in the interviews, to the analysis and interpretation. In each step of the process, temporal and contextual considerations are critical to understanding the deeper meaning of the situation.

**Methods**

I used a philosophical hermeneutic approach throughout this study, beginning with a feasibility study and ending with a full interpretation of findings. My original intent was to obtain two interviews, transcribe, analyze the results, and adjust the method as determined by the feasibility results, then complete the full study. However, responses to the recruitment letters came quickly, before the proposal for the full study was submitted. Seven potential participants responded and expressed a desire to participate. Since so many expressed a desire to participate, all participants were interviewed. Transcribing and analyzing the first two for the feasibility
study confirmed the original plan as a feasible method, revealing some foundational themes. I did not have the remaining interviews transcribed or analyze the remaining interview recordings until receiving approval for the full study. I included all interview transcript analyses in the final analysis. I received approval for a second IRB application before obtaining additional participants unassociated with the initial facility.

Feasibility Study

**Purpose.** Following IRB approval, I conducted a feasibility study from June 2011 to April 2012 to determine whether people who had experienced FFPR would participate in a research study discussing their experiences, and whether the methodology and method were appropriate to answer the research question and to refine data-collection techniques.

**Process.** Once the process for solicitation of participants was in place, three FMs who had experienced FFPR responded to the research letter and immediately scheduled interviews. Following each interview, I reviewed the process and the interview questions. I analyzed the first two transcripts seeking amendments to interview techniques and preliminary themes. Interview techniques varied between inquiry and therapeutic-communication techniques. Adjustments to the interview technique were the only changes made to the process during the first phase.

As a result of analyzing interview techniques, I was reminded to ask clarifying, inquiring, and elaborative questions; practice silence; and avoid therapeutic communication interventions. During the final two interviews, questions focused on clarifying and elaborating on specific comments, which kept the focus of the interview on participants’ experiences. The other feasibility question regarding whether FMs would want to share their story revealed that FMs were eager to talk about their experiences of FFPR. Questions asked during the interview were adequate to elicit the information needed for the full dissertation study.
However, obtaining more interviews for the full study proved difficult. Following the resumption of the study a year later, I sent only three letters and received no response. Personnel and staff who were stakeholders in the initial study were instrumental in identifying potential participants, but had changed employment. With a change in personnel, the facility has been practicing FFPR on a regular basis. An additional reason for the low response could be that FFPR does not happen very often. In conversations a chaplain at the facility, I discovered that when a patient needs CPR, many times FMs were not present, and by the time the family arrived, most resuscitation procedures have been completed. A similar difficulty in obtaining participants for a study was noted by Leske et al. (2012), in which resuscitation of the patient occurred before FMs arrived.

Participants for the feasibility study included FMs who had been present during CPR for events that transpired at least 3 months before the date of contact. Chaplains provided names of FMs approved by the medical. I sent letters of introduction that included a description of the purpose of the research and my name and number so potential FMs could contact me if they were interested in participating in the study. When an FM called to inquire about the study, I described the study and answered any questions over the phone. If the FM was still interested in participating, I arranged a meeting at a place and time preferred by the FM.

Seven people participated in the interviews. Participant demographics included five women and two men, ranging in age from the mid-40s to 70s; all were White. One interview included both husband and wife who had experienced the death of their child. The remaining interviews were with participants who had experienced the loss of their spouse or partner. Religious affiliations included Christian-non-Catholic, Christian-Catholic, and no religious affiliation. All expressed appreciation for the opportunity to talk about their experience of FFPR.
and stated it was helpful to talk about their experiences. In addition, all participants reported that, even though it was a very difficult experience, they would prefer to be present during resuscitation again. One person expressed disbelief that FFPR was not a standard practice.

**Summary.** The feasibility study demonstrated that the methodological approach was useful in addressing the specific aims and that the techniques for recruitment and data collection were sound. Therefore, I proceeded using the initiated methodology without major modifications. As noted above, modifications to the interview technique emerged, resulting in awareness of the type of elicitation questions would reflect an inquiry-based format. Washington State University IRB approved an amendment to solicit participants from outside the medical system of interest. I de-identified, had recordings transcribed, and analyzed all transcripts. The full study included all transcripts.

**Recruitment and Sample**

I recruited participants in two ways. The first recruitment series was through purposeful criterion sampling based on referrals from a medical center in Spokane. The second was through word of mouth referrals not related to the Spokane facility. Criteria for participation included being present during resuscitation (FFPR) of an FM with an FF present throughout the resuscitation event, over the age of 18 years, able to speak English, and at least 3 months post-resuscitation event.

The recruitment referral process for contacting participants began with chaplains from the Spiritual Care department. The chaplain present with an FM during FFPR submitted names of patients who experienced CPR to the medical director’s office. Once the medical director approved contact with the patient’s family, the department assistant mailed a letter of inquiry to the FM. The letter included a description of the purpose of the research, the study methods, and
my name and contact information. If the FM was interested, the participant initiated the process by calling me to ask additional questions and arrange a time and place to meet. At the meeting with the participant, we completed the informed-consent process, followed by the interview. The second recruitment source for participants was through personal connections and a snowball technique. These participants met all the criteria stated above except that the healthcare facility was different from the one originally identified. Once the IRB approved the revision, I completed the final interviews, had the data transcribed, and analyzed the data, included in the final interpretation.

The desired sample size for a philosophical hermeneutic study is the number of interviews it takes to achieve saturation or redundancy in content. At the outset of the study, the estimated number of desired interviews was 10–14 people. Knowing the actual number of interviews needed depended on the data revealed in each interview; the required number could be less than 10 or more than 14 to obtain data saturation. As information emerged, the number of interviews needed flexed according to new or redundant findings (Patton, 2002). As I completed the interviews, themes emerging as key to FFPR were reinforced, such as wanting to be with loved ones at time of death, wanting to know what was done, appreciating being present because it helped with the grieving process, and being able to advocate for and support the patient. Emerging themes that were not previously identified in research studies were (a) being strong enough to handle it, (b) everyone should have the choice, (c) reasons for wanting to be present, and (d) the importance of communication. I completed, had the recordings transcribed, and analyzed nine interviews.
**Human Subjects**

I obtained informed consent before interviews began. I informed participants of the following: (a) At any time during the interview, the participant could stop for any reason. If they wanted to continue the interview, they could and if they wanted to stop, they could. (b) I am a mandated reporter and must report anyone who expresses intent to harm self or others. (c) Risks to participating include the possibility of experiencing emotions of sadness, anxiety, or discomfort in sharing their story. (d) No direct benefits would accrue from participating, but some people have positive feelings from sharing their personal stories and that the knowledge gained could benefit others. (e) Participation was voluntary and would have no effect on their current or future healthcare services. (f) The interview would be audio-recorded and transcribed by a professional transcriptionist. Participants chose a pseudonym to be used during the interview to prevent identification by the transcriptionist. The pseudonym was coded and the list kept in a locked file, separate from the typed anonymous interviews. (g) I will destroy audio recordings following transcription and confirmation for accuracy. (h) Other researchers would read the de-identified transcripts and parts of them could be shared with students, health providers, or others who could learn from them. Results from this study will be published or presented at professional meetings, and no participants will be identified.

**Data Collection: The Hermeneutic Interview**

The primary method of data collection in interpretive phenomenology is face-to-face interviews, known as the hermeneutic interview. In philosophical hermeneutics, the interview, which involves a dialogue between the participant and the researcher, is the primary form of data collection. There is no prescribed format or predetermined list of questions. The researcher enters into the world of the participant through the participant’s own storytelling of a particular
situation. In this exchange, the interview begins with a standard opening question related to the phenomenon being investigated and designed to invite the participant into a conversation. The dialogue then proceeds with questions that are reflexive, open, and authentic (Vandermause, 2008). Questions asked during the interview are intended to clarify understanding, not to impose the views of the researcher. This dialogue is not just a checklist of questions for the participant to answer, but becomes a conversation that is fluid. The goal of the dialogue is not in merely reaching a destination, but the “destination simply becomes a ‘way station’ along the way, a standpoint” (Heidegger, 1951/1977, p. 12) on the way to deeper understanding.

The interview process becomes the journey to the horizon, a journey of listening, thinking, and responding. The researcher must be acutely aware of the flow of the conversation and be ready to take the right turn at the right time to continue on an enlightening path. During the interview, the researcher may encounter moments when the dialogue stops or changes direction. At times, the conversation may become less focused on the topic or reach a point when the participants don’t know how to proceed; the researcher must be aware and develop skills to bring the conversation back to the primary topic. The dialogue gives presence and acknowledgement to “that which is” at the moment. The dialogue should seek understanding, not just empirical data; “thirst for knowledge and greed for explanations never lead to a thinking inquiry” (Heidegger, 1959/1971, p. 13; Vandermause, 2008).

To begin the interview, I initiated conversation with the following opening statement to frame the dialogue: “As you know, I am interested in the experience of family members who have been present with a loved one who had CPR. I’d like to begin by asking you about your experience.” After the opening statement, the subsequent question was, “As you think about your experience of watching CPR being performed on (FM name), what stands out to you most about
the experience?” Throughout the interview, I asked open-ended questions to clarify and further explore the FM’s experience. I asked questions seeking more elaboration on the role of the FF such as, “How did the presence of the chaplain or nurse affect your experience?” Some questions were partial statements to provide encouragement for the participant to continue sharing their story, such as:

Tell me more about that.

What was that like for you?

What else was happening?

Anything more you remember . . . ?

Was there anything else going on?

Can you think of a “for instance”?

What stands out for you about that moment?

Analysis Process

**Data collection and transcription.** I sent audio-recordings of interviews to the certified transcriptionist through a secured password-protected website. I verified the transcript for accuracy by reading the transcript while listening to the audio-recorded interview. Then I shared the de-identified transcripts with the interpretation team for analysis and interpretation.

**Interpretation of data.** When using philosophical hermeneutic research methods, interpretation of data begins during the interview. The researcher keeps notes of thoughts, impressions, and observations throughout the interview; these data are known as field notes. For this study, I recorded field notes directly after each interview. I included analysis of these data in the analysis process and shared them with the interpretation team alongside the interview transcripts. The team of hermeneutic researchers, known as the hermeneutic circle, interpreted
the de-identified transcripts and field notes, seeking emerging themes and patterns. The interpretive process is not a prescriptive process, but the guidelines according to the Data Analysis and Management Using a Philosophical Hermeneutic Approach, outlined by Vandermause (2011), served as a framework for proceeding through the analysis process (see the Appendix).

The hermeneutic circle. The interpretive process involved reading the transcripts, thinking, reflecting and rereading them by to elicit themes from the texts by looking for “the hidden drift of the dialogue” (Heidegger, 1959/1971, p. 30). Hermeneutic interpretation is a science that deals with the goals, ways, and rules of interpreting literary works. Heidegger described it as a hermeneutic process that is not a theory or interpretation, but the attempt to define the nature of the interpretation on hermeneutic grounds (p. 11). Accordingly, the analytic process was iterative and reflexive: first, I read the transcript and looked for themes and patterns; then I gave members of the hermeneutic circle the transcripts to read and analyze. Meetings were organized using a collaborative meeting-planner site to find a mutual time for the group to meet. The circle met to share and discuss findings and analyses. Each person read their own analysis to the group; then the group discussed the analysis. Additionally, team members looked for plausibility, coherence, and comprehensiveness throughout the analysis process (Diekelmann & Magnusen Ironside, 2006, p. 262). After all insights from each team member had been revealed, the team and I worked together to “identify findings expressed as patterns and as associated themes that reflect overlapping and recurrent ideas” from the dialogue (Vandermause, 2008, p. 72).

This interpretive process was reflexive and iterative, similar to the interview process. The interview process ebbed and flowed in the conversation between the researcher and the
participant. As the dialogue developed from what was discovered, it influenced what was yet to be revealed. The interpretive process also flowed with the conversation among the members of the hermeneutic circle. Members of the hermeneutic circle focused on themes that evolved from small details, as well as how the particular words interacted, affected, and were affected by the whole story. As each component of the story was explored, developed, and analyzed, themes emerged that enhanced meaning and understanding. Hence, each theme built on previous revelations and affected subsequent discoveries. Like the interview process, the analysis process flowed iteratively among members of the hermeneutic circle, resulting in development and affirmation of interpretation that proceeded “in cycles of understanding, interpretation, and critique” (Diekelmann & Magnussen Ironside, 2006, p. 262).

The goal of the interpretive process was to seek meaning and understanding; therefore, members of the hermeneutic circle strove to understand and apply interpretive practices in each individual analysis (Kavanaugh, 2007). Researchers may be from similar or different backgrounds and bring their own lens of practice and life experience to the analytical process, providing a richer contribution to the interpretive process, and enhancing the process of understanding from a more holistic perspective. Members of the hermeneutic circle for this study consisted of experienced qualitative interpretive researchers, students at various levels of experience with interpretive research, as well as those from a variety of backgrounds in nursing practice.

The reader. The last stage of the interpretation process is with the reader of the research findings. The interpretive process continues in the same cyclical nature as the interview of the participants and the analysis of the transcripts. As the reader reads and interacts with the revealed themes and patterns of participants, the reader reflects on personal lived experiences with the
phenomenon, thereby affirming or negating the themes or patterns of the published findings (Diekelmann & Magnussen Ironside, 2006, p. 262).

Establishing Trustworthiness of Findings: Criteria for Evaluation

**Rigor.** Rigor, relevance, and congruency are guiding criteria to evaluate findings. In evaluating interpretive research, the criteria are fluid and reflexive but questions arise to consider in evaluating philosophical hermeneutics. Annells (1999) suggested the following questions as discrete criteria to evaluate rigor of an interpretive project:

1. Is the product understandable and an appreciable product?
2. Is there an understandable process of inquiry?
3. Is it a useful product?
4. Is the approach an appropriate inquiry approach?
5. Is the approach congruent with the stated methodology?
6. Does the question seek understanding and meaning or description and explanation?

Responses to the above questions provided guiding criteria to evaluate an interpretive project.

Another way to consider rigor is to determine if there is a balanced integration of content, author fit, and philosophical underpinnings. In addition, is there an openness and transparency in the research process as well as concreteness in the content? Is the reader able to relate to the findings? Do the findings resonate with the reader and further interpreted and actualized by the reader? (deWitt & Ploeg, 2006)

**Strengths.** Strengths of philosophical hermeneutics are the focus on understanding the experience of a person and the associated meaning in a given situation. If a nurse understands how a patient might experience a particular situation, care can be adjusted to make the experience meaningful with less trauma. Stories from participants in this study are rich in
content, helping readers who are unfamiliar with the practice understand its importance. A good hermeneutic study will provide information that can be useful to others in situations that are similar and “the reader can recognize common practices and shared experiences” (Diekelmann & Magnussen Ironside, 2006, p. 261).

**Limitations.** Limitations of this study included a small sampling group from one institution only and two participants outside the institution with similar demographics as the earlier participants in the study. Although the purpose is not to generalize findings to a broad population but to enhance understanding of members of this group through analysis of accounts from selected members, the study would be strengthened by sampling across institutions and from FMs with more diverse characteristics.

**Bias and prejudice.** Bias and prejudice in philosophical hermeneutics are part of the interview, analysis, and interpretive process. Heidegger and Gadamer believed that in the process of dialogue, moments arise when one reveals prejudices and biases. Researchers are aware of some of their biases and prejudices whereas other biases and prejudice are revealed in the interpretive process, and still others remain unrevealed or unknown. Hence, the willingness of researchers to engage in the dialogue is also an engagement process in which they reveal personal biases and prejudices related to the phenomena. This process is not aimed merely at learning about the participant, but for the researchers to learn more about themselves as well. Hence, presuppositions, prejudices, and prejudices are considered “the constantly operating unnoticed thinking that we bring to a situation as part of the understanding process. The prejudice becomes noticed only when it is provoked” (Gadamer, 1976, p. 9). As the interview proceeds, it is important for the interviewer to be aware of personal thoughts and reactions to what is revealed.
**Personal bias and prejudice revealed.** When beginning this research project, my bias about CPR was that CPR is an ineffective intervention with poor outcomes in cases of revival and that initiating CPR is a form of extending patient suffering. Furthermore, it prolongs life with expensive life-sustaining technology without ethical consideration of long-term implications. This opinion developed from experiencing only two successful resuscitations in the hospital setting over a 15-year period. Another experience contributing to this opinion is an 11-year period of work in hospice and palliative care in which peaceful and non-traumatic deaths with FMs present throughout the process was a common experience. Because of these experiences, I joked that the only tattoo I would ever get would be a goose-egg symbol over the letters “CPR” tattooed over my heart indicating my end-of-life preference.

Members of the hermeneutic circle also had personal biases regarding CPR and FMs being present in the room. A main topic addressed was the trauma of the resuscitation and concern about the effect on the FM. Additional issues were personal grief and loss experiences and how those experiences informed analysis of the transcripts.

With this bias, when presented with the option of doing this study, initially I was not interested because I did not want to do anything to advance the science of CPR. However, as the research on FPDR continued, I was struck that this issue is an end-of-life issue and the practice of FP is similar to the experience of FP in hospice and palliative care. Therefore, an initial intent of this study was to debunk CPR as a therapeutic practice. However, the surprise came when I realized the importance of CPR for other reasons than restoring life and began to understand the meaning of CPR for the FMs.

**This researcher’s bias changed by this study.** Although most patients in this study died, for most participants, a period of time intervened between the initial resuscitation event and the
final event. FMs valued this time to say final good-byes, get all the information they needed to make decisions about withdrawing life-sustaining interventions, and know all possible action was taken for the patient. Many FMs referred to this time-between as a gift of time or the miracle of CPR, even though some patients never regained consciousness and in all cases death eventually ensued. The value of this deathbed experience or deathbed vigil revealed the importance of being with the patient or loved one before and at the time of death. Being able to say final farewells is equally important in acute situations requiring CPR as it is in known situations in hospice care. Because the FM benefits from this, I resolved not to get the tattoo.
CHAPTER FOUR

FINDINGS AND INTERPRETATION

The research questions for this study focused on understanding the meaning of FM’s experiences of FFPR. Specific aims of this study include an interpretation of FM’s experiences of being present with a loved one during resuscitation and an interpretation of the FM’s experience of the FF during resuscitation. The findings and interpretations of this study affirm the results of previous studies, which stated that FM’s want to be present during resuscitation of a loved one (Clark et al., 2005; Hanson & Strawser, 1992; Lowry, 2011; Meyers et al., 2004). This study also confirms that FM’s being present is important for the following reasons: to know what is happening, to see the actions of the resuscitation team, to be able to be with the patient, and to be with their loved one at time of death (Clark et al., 2005; Hanson & Strawser, 1992; Lowry, 2011; Meyers et al., 2004). Findings from this study contribute a deeper explication of the meaning and nuances of the experience of FFPR. Following is a description of participants, a discussion of the surreal experience of time, the sacred nature of the entire experience, and the two main patterns of being guided through a surreal and sacred time and contributing to a successful resuscitation.

Description of Participants

Participants or FM’s in this study were all Caucasian, between the ages of 45 and 75. The ages of loved ones (the people receiving CPR) ranged between 16 and 80. One participant experienced the resuscitation of two loved ones, one a daughter who was resuscitated but dependent on life-sustaining technology; the other a partner who did not live. Two of the participants were parents of one child who was resuscitated twice but dependent on life-sustaining technology and never regained consciousness, resulting in a subsequent decision to
remove life support. Five other participants had loved ones who experienced revival from an initial resuscitation event with varying amounts of time before a final event; of these, one family decided to remove life support, three died following a final resuscitation event in the hospital, and one died following a resuscitation event at home after discharge from the hospital. One participant’s loved one had four resuscitation events, revived each time, and is still alive 1 year later following discharge from the hospital (see Table 1).

Table 1

Overview of Participants’ Experiences

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Relationship to patient</th>
<th>Number of resuscitation events</th>
<th>Patient regained consciousness</th>
<th>Time between</th>
<th>Final event</th>
<th>Time since last event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia</td>
<td>Female</td>
<td>Wife</td>
<td>2</td>
<td>Yes</td>
<td></td>
<td>Initiated CPR 1&lt;sup&gt;st&lt;/sup&gt; time 2&lt;sup&gt;nd&lt;/sup&gt; time Stopped CPR</td>
<td>3 months</td>
</tr>
<tr>
<td>Pam</td>
<td>Female</td>
<td>Wife</td>
<td>2</td>
<td>Yes</td>
<td>4 days</td>
<td>Stopped CPR</td>
<td>3 months</td>
</tr>
<tr>
<td>Lois</td>
<td>Female</td>
<td>Mother</td>
<td>1</td>
<td>No</td>
<td>1 day</td>
<td>Removed life support</td>
<td>3 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partner</td>
<td>1</td>
<td>No</td>
<td>0</td>
<td>Stopped CPR</td>
<td>3 months</td>
</tr>
<tr>
<td>Jim</td>
<td>Male</td>
<td>Father</td>
<td>2</td>
<td>No</td>
<td>5 days</td>
<td>Removed life support</td>
<td>3 months</td>
</tr>
<tr>
<td>Donna</td>
<td>Female</td>
<td>Mother</td>
<td>2</td>
<td>No</td>
<td>5 days</td>
<td>Removed life support</td>
<td>3 months</td>
</tr>
<tr>
<td>Betty</td>
<td>Female</td>
<td>Wife</td>
<td>2</td>
<td>Yes</td>
<td>5 days</td>
<td>Stopped CPR</td>
<td>3 months</td>
</tr>
<tr>
<td>Jerry</td>
<td>Male</td>
<td>Husband</td>
<td>1</td>
<td>No</td>
<td>7 days</td>
<td>Removed life support</td>
<td>3 months</td>
</tr>
<tr>
<td>Lynn</td>
<td>Female</td>
<td>Wife</td>
<td>4</td>
<td>Yes</td>
<td>3 weeks</td>
<td>Discharged still living</td>
<td>1 year</td>
</tr>
<tr>
<td>Mary</td>
<td>Female</td>
<td>Wife</td>
<td>2</td>
<td>Yes</td>
<td>4 months</td>
<td>Discharge Final CPR event at home</td>
<td>6 months</td>
</tr>
</tbody>
</table>
Setting the Scene: The Surreal and the Sacred Nature of CPR

Being present while a loved one undergoes resuscitative measures in efforts to restore vital function to a lifeless body is a surreal experience. The intense life-altering implications of the situation affect an FM’s perception of time, causing the circumstances of the situation to seem irrational and unbelievable, as if in a dream. When reflecting back on the experience after 3 or months of the event, most participants commented about the imperceptibility of time: the experience felt like it lasted forever and was unreal, surreal, and like a dream. Along with the feeling of an altered sense of time, an undercurrent of the experience being a sacred moment also emerged.

Surreal Time

_Kronos and kairos_ are Greek words used to differentiate time as chronological and time as a significant experience. _Kronos_ time is a quantitative term defined as chronological or sequential time or as a specific moment in time. _Kairos_ time is a qualitative term defined as a moment of indeterminate or inexplicable time in which something special happens or a time when everything happens; it is an opportune or decisive moment, also referenced as a time between or a time lapse (Merriam-Webster, kairos). “It is a moment of authenticity, where there is no anchoring to the past, it is a period of space” (R. Vandermause, personal communication, May 25, 2016).

Being present with a loved one experiencing resuscitation is an experience of a moment in time that is blurred with the unreal nature of the experience. Many participants described the experience as feeling _surreal_. Merriam-Webster Dictionary defined surreal as an experience “marked by the intense irrational reality of a dream” (Merriam-Webster, 2016, para. 1). The FMs’ sense of time is altered; time seems to stand still, and yet, a few minutes seem like an
eternity; as Jerry expressed, “the CPR went on for 17 minutes which was, um, uh forever, an eternity” (7.60, 751).

In discussing the experience of FM’s being present during resuscitation of a loved one, the experience of time seemed nonexistent and the ability to recall the exact chronicity of events was difficult. Mary’s recall of time and events in some situations was quite detailed, but the ability to recall the duration of time for specific situations or time between events was more difficult. For example at the beginning of the interview, she stated it was a year and a half between the first resuscitation and the final event, but then, as she talked more about the events, the time between decreased to 4 months. For many, kairos time became the prevalent experience of time, and details related to kronos time lacked clarity, thereby contributing to the dreamlike, unreal, or surreal nature of the experience. The imperceptibility of time was apparent as Pam shared her thoughts upon entering the room escorted by the chaplain:

And um, I was, um, just across the street at the hotel, and he was getting ready to come home the next day (2.131-133) … and I had no idea. I kept thinking, well, he’s going to—I mean, he’s going to come through this. He always comes through. You know? Um, he came through the surgery. We’re going home. (2.201-210).

Then she asks the chaplain,

“How long does this go on?” And I vaguely remember somebody saying, “As long as you want us to.” You know I’m not sure if they really did. I’m not really sure if everything I recall really happened. But this is in my memory (2.230-235).

The sense of displacement and the surreal perceptions surrounding this profound experience are palpable as FM’s replay the events leading up to the final moments of their loved one’s life. During the first episode of CPR, participants experienced time as unknown and
surreal, like the intense reality of a dream that coincides with a waveri
experiences, privately held beliefs, and meaningful practices. They also embody a sense of connectedness to self and others in relationship (Reimer-Kirkham et al., 2012, p. 204).

Western medicine has created its own sacred spaces in various areas of healthcare institutions. Many of these sacred spaces do not allow outsiders or the layperson to enter. Entry into these areas is permitted for persons educated about the purpose, protocol, and core values of the sacred space. However, entrance is restricted for persons without the appropriate training. For example, the surgical suites are areas with layers of procedures for admittance, and only certain people can enter without restriction. Likewise, in a resuscitation event, the space around the patient’s bed becomes the sacred space in which only the qualified and trained are permitted at the bedside.

With the nature of death experienced as unexpected and unjust, the fight for the return of life to the loved one ensues. Thus, some belief systems have developed rituals to negotiate with death for the return of life, or for assisting the loved one on a “good journey of the departed soul” by the spiritual guide, healer, and priest (Tercier, 2002, p. 301). Historically, the person to lead the ritual proceedings was the priest or spiritual leader of the community. Today the resuscitation team leader leads the fight to revive. Thus, the arena of CPR is the new sacred space in which the fight for life occurs. In this space, the physician, nurses, and staff all perform their roles/rituals in fighting to bring life back into the person’s body. Each element of the ritual, or resuscitation intervention, builds on previous actions and leads to the next, based on the body’s response. In performing the ritual of CPR, the practitioners become different people. People who in their everyday practice use their hands to comfort and heal now use their hands to invoke “therapeutic violence” on the body as part of the ritual to restore life (p. 293).
With the practice of inviting FMs into the CPR arena or the sacred space of CPR, a collision of rituals ensues. In this one area of sacred space, resuscitation-team members implement their medical interventions/rituals to restore physiological life to the patient. FMs are practicing their own rituals of hoping, praying, and advocating for their loved one in the battle between life and death. Because FFPR is a crisis, no one has time to orient and train the FM; therefore an FF assists the FM to be in the sacred space of CPR to explain the interventions and responses to enhance understanding. Thus having an FF serve as an interpreter, a guide, and a support person for the FM, the FM is then qualified to be present in the sacred space of resuscitation at the patient’s bedside. With the FF present, instead of the sacred space of CPR being a collision of two separate sets of rituals, it becomes a space where the two different ways of approaching the situation work together toward one goal: restoration of the patient/loved one’s life.

A unique aspect of being in this sacred space is that the spiritual/religious beliefs of the patient and FM merge with the medical interventions/rituals of the resuscitation team; each functioning independently yet simultaneously while engaged in fighting the battle in overcoming death. Being present during CPR of a loved is a sacred experience in the substantial sense, due to the ultimate significance and meaning associated with the experience, and in the situational sense of connectedness to others in previously developed relationships. Even though the place of CPR is transitory, occurring wherever the patient is at the time of cardiac arrest, the implementation of CPR creates a unique space around the patient: the sacred space of CPR.

As participants shared their experiences, the nuances of a surreal time and the sacredness of the event were undercurrent tones in the telling of their stories. The following experiences of
being guided through a surreal and sacred time and contributing to a successful resuscitation

occurred in a surreal and sacred space, as illustrated in Figure 1.

Figure 1: Diagram of facilitated family presence during resuscitation.

**Pattern I: Being Guided Through a Surreal and Sacred Time**

Being present while a loved one undergoes resuscitative measures in efforts to restore vital function to a lifeless body is a surreal experience in which the perception of time and reality is altered. The intense life-altering implications of the situation affect the perception of time and the circumstances of the situation may seem irrational and unbelievable, as if in a dream. This pattern primarily reflects the aspect of the FMs’ experiences of being present during resuscitation of a loved one in which an FF was present with the FM. Characteristics of this pattern include
being invited and ushered in, being guided through the experience, and being included in the decision making.

When an FM is notified of a life-and-death situation involving a loved one, the FM is immediately thrown into a strange and surreal state; one in which the person experiences feelings of helplessness, powerlessness, and confusion. In this study, chaplains (spiritual counselors) served in the role of the FF in the hospital setting; in the one situation that occurred at the participant’s home, the FF was a police officer. In some situations, multiple chaplains provided care throughout the entire experience. The role of the FF is to assess the FMs emotional state, determine the FM’s appropriateness to be in the resuscitation room, and notify the resuscitation team of the FM’s arrival. The FF offers an invitation to the FM into the resuscitation area and then accompanies the FM throughout the resuscitation event whether the FM stays in the room or chooses to leave. The FF assists in helping the FM understand the implications of the patient response to interventions and answers questions for the FM (Hanson & Strawser, 1992; Robinson et al., 1998).

Whatever the outcome of the resuscitation event, communication with the FM(s) provided a sense of comfort in being present during a traumatic event. In the moment of being notified or realizing that a loved one is teetering between life and death, knowing what is happening, what to do, and where to go are key in being able to handle the situation. As expressed by Pam and Betty:

I got there and I didn’t know where to go, so when I walked in the chaplain was there and told me what had happened, asked me if I wanted to go in, and took me in and told me where to stand. (2.204)
I would recommend someone to be with the family if they want to stay in the room. They need somebody with the wisdom and the strength to kind of help ‘em—to help ‘em along.

(6.311)

Overwhelmingly, FMs stated that although the trauma may be too much for some to handle, everyone should be given the option to be present, but someone should be there to support them.

**Being Invited and Ushered In**

Concerns by nurses and other healthcare providers about FMs witnessing CPR as being too traumatic has been an important historical reason FMs have not been allowed to be present in the room (Critchell & Marik, 2007). Several researchers have debunked this myth, revealing the healing and therapeutic effects for FMs in the grieving stages following resuscitation attempts and death of a loved one (Hanson & Strawser, 1992; Robinson et al., 1998). Likewise, for participants in this study, being present in the room during resuscitation of their loved one was driven by a deep inner need to be with and near their loved one, despite the violence of resuscitative interventions.

In the moment, the FM is notified that a loved one is experiencing any kind of suffering; the immediate unadulterated first response to any apparent distress is the desire to know what happened and to go to that loved one to evaluate the situation for oneself. The innate desire and need to be present with and to comfort a loved one in distress is a core human relational response (Kessler, 2007). Accordingly, all participants in this study wanted to be present with their loved one who was experiencing CPR, as everyone expressed in the phrase “I wanted to be there!” The trauma of the situation was not a deterrent, but “being there, no matter what” was of utmost importance to every participant.
Traditionally, only those who knew the ritual of CPR have been present in the CPR arena. As the sacred-space of the CPR arena has been opened to the layperson, the veil has been lifted and the mysteries of CPR revealed. However, the layperson does not know the rules of what to do, where to go, and how to act. The usher becomes the one who extends the invitation to enter the arena, as well as the guide to being in the unknown mysterious experience. The sense of the arena of CPR as a sacred place was insinuated by Pam as she referenced the chaplain as an usher inviting her into the sacred space: “The chaplain was kind of there at the door, and he kind of ushered me up to the bed” (l. 204). The use of the word usher implied a sense of being escorted somewhere (sacred or special) and, in this case, into or out of the CPR arena. Jerry also used the word usher, but more in the sense of what he would do if he were not allowed into the room. He stated, “If someone had ushered him out, he would have been fighting mad!” To be removed from a sacred place implies a sense of unworthiness, or a lack of qualifications to be present, or considered as an intruder into a forbidden area. Jerry may not have felt he truly belonged in the room with his wife because he did not have the knowledge or expertise in performing CPR: “I don’t know anything about CPR, … but there was no way they would have kept me out” (7.50, 230). Lois, in contrast, did not wait for an invitation, but insisted on being present inside the CPR arena because she felt she had valuable information the resuscitation team would and should want.

**Being Guided Through**

The chaplain also provides a comforting presence for the FM when the code had stopped, being with the FM and helping loved ones to say goodbye and figure out what to do next.

When I arrived, the chaplain took me where I needed to go. … He kind of ushered me up to the bed … took me to the head of the bed and stayed with me. The chaplain was there,
it was comforting, he was just there with me, you know, I remember seeing “no religious preference” on the paper, because we had said that. He wasn’t pushy. He didn’t try to tell me he’d gone home to Jesus—or I mean, he respected. But he was there for comfort and kind of knew what I needed next. He was just, you know, a real comfort.

Knowing the religious preference of the patient and family provided a frame of reference for the chaplain and the healthcare team to support the family in a helpful manner. As noted in the quotation above, the FM expected the chaplain to push a religious perspective on her, but instead the chaplain expressed an unexpected feeling of support and respect for their personal beliefs. The chaplain was able to provide comfort in speaking to her needs in a language comforting to her. Others expressed comfort in the chaplain being able to speak to their religious language. “The chaplain prayed with us. It was nice to have someone who speaks the same heart language.”

Realization that life would not be the same, Betty expressed her great appreciation for the chaplain. She said that she just kept thinking to herself,

What am I going to do next? Then the chaplain came, he just knew what I needed. He knew what to say and he brought me a brochure. It was like a talisman for me. It told me exactly what to do next. I held on to that brochure for a long time.

Verbal support as well as written support was a valued help to Betty in figuring out what to do next, and others expressed the desire for a brochure or pamphlet providing such support. Patricia expressed the desire for a checklist following death of a loved one: “It would be great if someone gave you a checklist of things to do afterwards.”
Being Included in Decision Making

FM’s did not forthrightly express their experience of the facilitator’s role and presence, but all verbalized it was important that every FM should be given the option to be present, even though they may not be strong enough to handle it and that someone should be with them. The facilitator was a conduit in providing hope. “The chaplain and the nurse knew what to say and this was helpful.” In contrast, when a doctor attempted to explain the situation to determine further interventions, often a medical-language barrier and the confusing situation was unsettling because the FMs did not understand and had difficulty knowing what decision to make.

Several participants related their appreciation for being included in the decisions regarding continued interventions during resuscitation of their loved ones. Lynn felt included in decisions and was impressed that the doctor left the resuscitation scene to come to where she was standing in the room to discuss treatment options. The doctor also conferred with Betty and Pam while in the midst of performing the final CPR about their requests to stop the CPR. In this situation, the inclusion was just “Do you want us to stop?” There was no explanation of options or probabilities. Although they said to stop the CPR, a lingering element of guilt and doubt emerged in wondering if they had stopped the CPR too soon. However, after talking about their experience for this study, they felt more assured in their decision to stop CPR.

Including FMs in decision making during CPR was confirmed in situations in which FMs were not included in the decision-making process. For Mary, though she was present in the resuscitation room, no FF was present with her during resuscitation, and no one spoke to her or acknowledged her presence. Her husband survived, but not being informed about the plan or even acknowledged was a distressing experience. In contrast, the final resuscitation experience was a very different and positive experience because the FF discussed each decision that needed
to be made with her and then pursued her choices. Even though her husband died, her experience of the second resuscitation event was a more positive experience than the first. Likewise, Lois wanted to be present to stop the CPR because of the complicated health history of her daughter and became frustrated when she felt that she was being delayed entry into the room and could not tell the doctor to stop. Participants whose loved ones survived CPR and were included in decision making regarding future treatment also expressed their appreciation in knowing what was happening throughout the resuscitation event.

**Pattern II: Contributing to a Successful Resuscitation**

In crisis moments involving a loved one, an instinctual response was to want to help, to do something that is beneficial for the person suffering, or to know that they were receiving the best help possible. The second pattern represents the aspects of being present during resuscitation that FMs considered important to a successful resuscitation. It is important to note that a successful CPR event in this study was not determined by whether the patient lived, but was measured by how much the FM was involved in the process. Aspects of contributing to a successful resuscitation include *honoring the relationship, advocating for the patient, and being present at time of death.*

**Honoring the Relationship**

Personal inner strength is a perceived characteristic that each participant attributed to self. Every participant mentioned strength in the ability to handle the trauma of CPR as a key characteristic in being present. Participants stated, everyone should have the choice to be with their loved one if they want to, but it should not be required, if FMs do not want to be present. Jerry and his wife had been open about their preferences at end of life and discussed it because of her chronic condition. Knowing about the condition, the prognosis, and expectations was a
source of comfort and strength for Jerry. “I wanted to be present, but not everyone may be able to handle it and not everyone may want to be present and they should have the choice” (7.285-291). Despite having all the information and expecting an early death due to her chronic health condition, it was “still unexpected when it happened.” Strength of character and strength of relationship was important to Jerry. All participants commented on being strong enough to be present, but also cognizant of the fact that this was not an experience for everyone, though everyone should be given the option to be present if they desire.

Betty felt that being present was an extension of their wedding vows of “‘til death do us part.” Because of their commitment to each other, 56 years of marriage and doing everything together; she said, “I wanted to be there!” Many of the participants had been married between 45 and 56 years. In these long-term, intimate relationships, the spouse knew the patient’s preferences and health conditions and was thereby able to provide important information to the resuscitation team. By inviting FMs into the resuscitation room to witness and be near their loved one during resuscitation attempts, the mystery surrounding death and the efforts of CPR were reduced (Atwood, 2008; Mohammed & Peter, 2009). The limitations of the interventions were observed first-hand, the reality of CPR effectiveness was apparent, and FMs were able to be part of the experience. As Jerry expressed, “It’s not like on TV, it’s way different.”

Even though the patient is the recipient of the resuscitation efforts and the object of the family’s hopes, some believe the patient plays a role in the outcome of the resuscitation, as in the statement, “rooting Jane on.” This statement implies that it is Jane, the patient, who is ultimately doing the fighting to survive or to come back. There are team actions that contribute to preparing the way physiologically for the body to live, but also the idea that Jane has her own responsibility in this event. Jane’s responsibility is an unknown action, a spiritual action perhaps,
a will to live, a choice to overcome, or the option to succumb to the enemy pulling her from life. This contribution to the process by the patient was also reflected in Betty, Pam, and Jerry’s stories when they stated, “they brought him back” (6.624), “You know, she—she died—or I guess you say died and they brought her back” (7.685); even more poignant was Betty’s husband stating, “I actually died and came back.” These statements imply a sense of movement from one place to another and a choice to leave or to come back.

**Advocating for the Patient**

Hope during CPR is a time of desiring the best possible outcome, and knowing the worst possible outcome is likely. In being present, FMs felt they were able to do something to help. Having hope in the outcome was something they could do. The resuscitation team focused on the resuscitation and the FM focused on the patient. In this battle with death, thinking any other way is pointless: “You think, she’s going to make it, you don’t think, she’s going to die” (5.218-219). FMs during resuscitation had current knowledge of the patient’s condition. FMs did not have to endure not knowing or wondering what was happening. “It was a relief when she stabilized; it gave us more hope” (5.173).

Watching out for the patient was portrayed as actions that are similar to the vigil-theory concept of protective watchfulness in which family and friends gather at the time of impending death (Kellehear, 2013). Such activities include sharing information and stories, being with the patient, touching and comforting the patient, and praying for the patient. Despite the traumatic nature of resuscitation, Jim, Donna, Betty, Patricia, Pam, and Lynn also recounted their experiences of watching CPR: all were glad they were present in order to feel they could do something. Being there and knowing what their loved one experienced provided a better understanding of the situation when discussing options with the doctors later.
Patricia became quite animated in talking about the last and final code for her husband. She expressed being angry after the chaplain called her a second time, while she was driving to the hospital, to ask about stopping the code. She insisted on being present before the code was stopped because preserving his wishes was important to her: “I knew what he wanted.” Patricia, advocated for her husband’s increased healthcare needs during his final year of life. She continued that role as an advocate for him in his final moments: “He wanted everything done, I had to be there to see that a full code was done.” In contrast, Lois wanted to be there because she wanted resuscitation stopped on her daughter. In a subsequent event in an attempted resuscitation of her life partner, she had information she felt was important for the code team to know in their efforts, thereby fulfilling the role of knower of vital information. This was a role she played in the lives of family, friends, and those she helped. She also assumed this role with her life partner and was adamant that the code be stopped because she had a copy of the living will indicating that resuscitation was not wanted. Whereas, Jerry and his wife had worked together throughout the years managing her chronic condition and, even though they had discussed end-of-life preferences, additional time was needed to make any consequential decisions. Being present gave Jerry the added knowledge he needed to act on their previous discussions and decisions. “I always watched out for Beth. I can’t overestimate how close we were. … It was my duty to be there. I wouldn’t have it any other way.”

**Being With at Time of Death**

Allowing the FM to be present is a practice that reunites the dying with their loved ones as part of the traditional deathbed wake vigil, thereby enabling closure and providing the opportunity to say good-bye. The concept of sacred space was not a concept mentioned overtly by participants in this study, but as participants described various situations throughout their
experiences, there were moments in which the FM changed the tone of their voice, and the flow of their speech became more reflective and pensive in mood. They described the moment they knew the patient was gone. Pam stated, “I knew, I knew he was gone.” (2.269). Lynn, in talking about being with her mother when she died said, “I knew the moment she died. I could feel her spirit leave her body, and if George had died I would have wanted to be there for that moment.” (8.694). Mary also said she thought Bob was gone, but because of the POLST form, and he wanted CPR, she initiated CPR and did not stop it until it was stopped by an HCP.

Historically, ritual and symbolic actions, words, and personal presence surrounding the death of a loved one had significant cultural and religious meaning (Tercier, 2002). For many participants, being present at time of death was important because of their belief in an after-life: “I believe when you die, your spirit leaves your body right away. … When my mom died, I felt her spirit leave” (8.688, 694). Betty wanted to be there in case he did come back. “It’s hard watching them go through that, but watching him come back, … made you feel he was going to beat it again” (6.624-627). The sacred space of resuscitation, the sacred moment of death, and the medical practitioners’ ritualistic fight for restoration of life intersected and became a symbolic ritual, providing assurance to the FM that all possible action was taken to restore life. If revival did not happen, then it was the person’s time to go. Participants described the wondering and not knowing as worse than seeing the trauma of CPR: “It would have been way weirder to just be called and told he had died” (2.526).

“Watching go” is an experience of witnessing death, of seeing the last breath and knowing that death has come. Betty expressed the confusion, the trauma, the inability to recall details of the moment and her reaction to not want to see any more harm done to her loved one and she instinctively turned away. It is in that fleeting self-protective moment of turning away
from witnessing harm to another and the warning battle cry of “stop hurting him” that brought the most turmoil to Betty. Betty and Pam stated they knew their husbands were gone when they yelled out for them to stop the code, as the code teams were getting ready to defibrillate. Rationalization for stopping the code was verbalized as a plea to stop hurting them. During the first code, defibrillation was not identified as a harm-inducing act, but during the second code it became an intolerable act to witness, thus their need to stop CPR.

Why did Betty and Pam want the CPR stopped? The first time was successful, why would they not want to continue in hopes of a second successful revival? Was there an intuitive sense or feeling that their loved ones were not revivable? Both stated they “knew he was gone.” Why this time and not the first time?

Because, I sort of knew he was gone … they began talking about cardiac needles. … I knew I didn’t want them to do that. I knew Dan wouldn’t have wanted that. We talked about it, so, I knew. … And when they stopped, I just couldn’t seem to stay in there watching him go. You know? I think because I watched him go once. (6.201-204)

By the end of the interview, Betty reconciled some of the doubt and wondering as she lingered on the possibilities of her decisions. After retelling the story and various aspects of the experience for the third time, she reconciled the story with, “he may have known more than we knew … we meant a lot to each other … we had a good life. … I’m not ready to give it up” (6.1087-1097).

Mary also recognized that Bob was gone, but for her it was important for the CPR to be done, because he had wanted it done. It was meaningful for her to witness the resuscitation team doing their best and everything possible to revive Bob. Their efforts provided her with the assurance that it was his time to go.
They did everything—extremely professional. There was nothing that indicated to me that they were blowing this off, that this was as important as anything (9.120-125). … The fact he wasn’t responding, the fact that, they may very well in their own minds have thought he had passed—they still maintained their professionalism and did what they needed to do (127-132). They preserved his dignity by covering his genitals (399). And I just felt—a trust (385). Very professional … no hysteria (144), … no joshing around (145). … Nothing was being left undone (154). I guess I knew it was all for naught, It wasn’t going to be—change the outcome (172-173). But they did it anyway (176). Had they been able to, they might have been able to save him if there was life there (206) … So it was his time (215).

Although most of the patient’s in this study died before discharge from the hospital, the FMs referred to the time with their loved one between the first episode of CPR and the second episode of CPR or the withdrawal of life support as a gift of time. Even the FM of the patient who survived remarked on the time between the four resuscitation events and discharge to a rehabilitation center as a precious time when the family was together, reminiscing, and reconciling strained relationships.

Time with the deceased after death was also important for the FMs. Wake and vigil theories discuss culturally and religiously influenced activities that ensue following the time of death. Being present at the time of death is an important moment for FMs. Many traditions take part in vigil-theory practices, providing support for the dying person’s soul: cleaning and dressing the body, providing time and space for the family to be with the patient, and offering prayers for the deceased in sending him or her on a spiritual journey (Kellehear, 2013).
After the resuscitation ended and everyone had left, being able to sit quietly with their loved one’s body and FMs were moments considered to be precious for participants. Participants commented about the peaceful appearance of their loved one’s face, being able to touch and talk to them, and help the nurses clean them up.

The nurses were so kind. They offered to let me help, but I said “No” and then I realize that I have a washcloth in my hand washing his face. It felt so natural. The nurses helped me clean him up and let me spend as much time as I wanted with him. (2.305-308) Friends came and sat with me, he was at peace, he had a smile on his face, and everyone saw it. The nurses let us stay as long as we wanted, and after a while, it just felt like it was time to go and we left and they took care of everything. (1.251, 257)

Having the opportunity to say goodbye after death was just as important as time with their loved one before time of death. This was time for FMs not present during the resuscitation to be with the deceased to say good-bye. Awareness of patient-family preferences and practices at time of death was helpful in facilitating this time for FMs to be with the patient after death. Some participants preferred time alone with the deceased; others appreciated prayers offered by the chaplain, and “do-not-disturb” symbols posted outside the door, allowing the family uninterrupted privacy. Attention to family needs after time of death promoted a smoother transition from the moment of death of a loved one to returning to one’s life without that loved one.

**Summary**

Being present with a loved one during resuscitation is a complex and multifaceted experience. The experience is surreal and timeless. It is sacred. It is important to FMs to be able to be present during CPR and at the time of death. Being present during resuscitation of a loved
one restores the practice of traditional bedside vigils. As indicated in the first pattern of being
guided through a surreal and sacred time, having an FF present with the FM provides someone to
invite the FM in and to guide them through the experience, supporting them during and
following CPR, and including them in the decision making. The second pattern, contributing to a
successful resuscitation by the FM includes characteristics of honoring the relationship, being
with the patient, and advocating for the patient. Overwhelmingly, the message from all
participants was that if FMs desire to be present during CPR, they should be given the option.

For FMs, a successful resuscitation is not just restoration of life, but is being able to be
present, knowing all possible action was taken, and being included in the decision making. FMs
want to know what happened during resuscitation, want everything done until it is apparent that
resuscitation is not going to revive the patient, want input into decisions regarding interventions,
and, most importantly, want the option to be with the patient during the last moments of life. At
the point of initiation of CPR, FMs do not know if the resuscitation attempts will be successful,
so being present assures the FM they will be present during the final moments, especially if the
CPR is not able to restore life.
CHAPTER FIVE

DISCUSSION OF FINDINGS

This study reveals that from FM’s perspectives, a successful resuscitation can happen even when the patient dies. FPDR is becoming a more accepted practice in healthcare. In the pediatric population, the expectation is for parents to be present during resuscitation of their child. However, in the adult population the practice is neither universal nor consistent in implementation. Findings from this study affirmed the practice of FMs being present in the room with a loved one during resuscitation. Equally important to being present with a loved one during resuscitation is the manner in which an FM is included in the resuscitation process. A paradox exists between what healthcare providers consider a successful resuscitation and what FMs consider a successful resuscitation. Return of life following CPR is the usual criteria for healthcare providers in considering a CPR event a successful resuscitation. However, a successful resuscitation for FMs is not necessarily a return to life, but includes being able to be present, knowing the purpose for everything that was done, being included in the decision-making process, being able to say good-bye, and being present when the patient dies.

Participants in this study were present with a loved one during at least one resuscitation event and had an FF present with them during at least one resuscitation event as well. At least 3 months had transpired from the time of the latest event to the time of the interview. Of the nine participants in this study, one experienced FFPR with two loved ones, and two of the participants were parents of one child. Most participants were spouses or partners and three were parents of the patients. Two participants had loved ones who lived and were discharged from the hospital. However, of the two, one died within 4 months of discharge and the other one was still living 1 year later at the time of the interview.
At the beginning of each interview, I instructed participants to begin talking about whatever was foremost in their mind about the situation. As participants shared their experiences, I asked subsequent questions to clarify the situation or encouraged them to keep talking, with occasional redirection when the subject matter strayed far from the topic. If the participant had not talked about the facilitator, I asked them to share their experiences with the facilitator during the resuscitation. Toward the end of the interview, I provided a brief synopsis of key meaningful moments and then asked participants to speculate about what it might have been like not to be able to be present during the resuscitation. As each interview occurred, themes and patterns emerged that were reinforced with each subsequent interview. Each member of the hermeneutic circle, comprised of four to seven hermeneutic researchers, completed analysis and interpretation of each transcript. The primary overarching patterns identified in this process were being guided through a surreal and sacred time and contributing to a successful resuscitation. Next, I explore implications for practice, education, and future research in this chapter.

Implications for Practice

It is important for healthcare providers to recognize the psychosocial and spiritual bonds between a patient and loved ones, especially in life-and-death situations. Findings from this study reinforced the results of previous studies reporting that FMs want to be present at time of death with their loved one. It was important for saying good-bye, knowing what happened, and knowing that all possible action was taken (Atwood, 2008; Hanson & Strawser, 1992; McMahon-Parkes et al., 2009; Meyers et al., 2004; Robinson et al., 1998).

Any unplanned hospital admission is an acute and uncertain circumstance in a person’s life. Therefore, inclusion of significant FMs in the discussion of desired practices at time of
admission can assist the healthcare team to provide more appropriate, inclusive, and timely care to the patient. In the practice of FFPR, FMs are strangers to the emergency department or intensive-care-unit environments and are unfamiliar with the language, routines, and procedures. Therefore, providing an FF to help the FM navigate and understand the situation is critical to the success of FP during resuscitation.

**Being Guided Through a Surreal and Sacred Time**

In the pattern of *being guided through a surreal and sacred time*, FMs need a guide to help direct their actions, an interpreter to help them understand the implications of the patient’s response to the interventions, and an advocate to facilitate their inclusion in the decision-making conversation. Recognition of the innate human need and response to be with a loved one, especially during a life-threatening situation, acknowledges the emotional bond between the patient and family and the inherent humanity of the patient (Clark et al., 2005). As a result, even during the violence of CPR, the innate need to be present, to know what happened, to be able to encourage the patient and the resuscitation team, to know that all possible action was taken, and to be with the patient at time of death is of utmost importance to the FM (Fanslow, 1983; Hanson & Strawser, 1992). The violence of CPR embodies a deathbed ritual that provides a visual social function indicating that everything possible was done to restore life. However, if unsuccessful, death signifies the ritual’s end and that death has happened (Kellehear, 2013; Mohammed & Peter, 2009; Tercier, 2002).

CPR situations may require further input from FMs regarding desired interventions. Having the FM present in the room promotes an opportunity for collaboration in decision making. FMs trust resuscitation-team members to do all they can to restore physiological function. Meanwhile the FM focuses on praying for, encouraging, and advocating for the patient.
However, at the point where the resuscitation team needs feedback, the FM, the lead resuscitation-team members, and the FF can discuss the implications for each treatment option and make a collaborative decision that is the most satisfactory experience for FMs. Situations in which the resuscitation team leader simply asked, “Do you want us to stop the code?” and the FM responded with either “no” or “yes,” is not collaborative, and has long-term implications for the FM. Several participants mentioned that the doctor asked them if they wanted the CPR stopped.

I remember, I cried out “No” when they were going to do the shock and I just couldn’t bear to watch them do that to him again. The doctor asked me if I wanted them to stop and I said “yes” and left and I don’t know what else they did, but I wondered after that … if I made the right decision (7.545).

If it is apparent the patient is not responding to the resuscitation interventions, the resuscitation team leader could discuss the lack of response with the FM with the recommendation to stop the CPR and request permission from the FM, rather than asking the FM to make the decision to stop the CPR. Though this distinction may seem minor to HCPs, for the family it may be quite significant in how much guilt they carry about the outcome. FMs continued to struggle, 3 months later, with a sense of guilt that they may not have tried long enough.

If the patient’s life is restored following CPR, FMs experience great joy, but also concern about prognosis. Despite restoration of life, there are lingering questions regarding prognosis, quality of life, rehabilitation, withdrawal of interventions, and the questions, “What if it happens again? What do we do, now?” This apprehension is an opportunity to include the family in discussing future treatment options and end-of-life preferences. Following restoration of
physiological function, FMs, doctors, nurses, restorative therapists, and chaplains need to engage in discussions about end-of-life preferences and discuss how to proceed in case of a repeated need for resuscitation. It is imperative that healthcare providers consider their roles and words carefully, to avoid placing undue heavy burden on FMs in making decisions. Life-altering decisions can be made from seemingly insignificant remarks, as Jerry described the team discussing his wife’s prognosis and paralysis. He had been asked by the nurse how he thought she would handle being in a wheelchair, and a nurse quipped, “If she even makes it that far.” Based on that one comment, the family decided to pursue withdrawal of life support, because of the perceived lack of quality of life. The CPR provided the time to make an informed decision.

Following the death of the patient, FMs appreciated the time and ability to be with their loved one’s body, to be included in cleaning the body after death, and the freedom to take as much time as needed to be with the body. These were poignant moments in the experience.

Guidance received from nurses in cleaning the body and the gentleness with which nurses cared for the body were meaningful to the FM; their gentle and caring actions seemed symbolic and commensurate with feelings FMs had for their loved ones (Kellehear, 2013). Participants talked about the appearance of their loved one following resuscitation attempts. “He was so peaceful.” “He had a smile on his face.” “She looked like she was at peace.” Length of time needed with the patient’s body varied according to the family, but each participant shared their appreciation that the staff allowed them a private space, with no interruptions and unlimited time to be with the patient’s body. Some prayed, others told stories, and all commented on the appearance of their loved one. Nurses included the FM in cleaning the body and, much to their surprise, this became a healing activity for the FM. One FM commented that as they left, they noticed a special sign on
the door to notify people not to enter the room. The guidance the nurses provided the family was helpful in facilitating FMs’ grieving.

Some participants received an instructional brochure that provided guidance about “what to do next.” The brochure provided information and guidance about what to take to the mortuary, making funeral arrangements, and things to consider, such as wills and financial accounts. Another participant recommended the provision of such a document and felt that more guidance following the death of a loved one would be very helpful. Pam stated,

He was a great comfort. … I remember thinking; I don’t know what to do next, should I stand up? You just don’t know! Oh, my gosh! What now? Then he handed me the list. I thought why is he handing me a brochure, but it wasn’t, it was a list of everything to do and suggestions on what to take. For instance, what information to take with you to the funeral home. I mean … you just don’t know this stuff. I carried it with me everywhere I went for the next week (2.312-319). Written instructions were very helpful.

**Contributing to a Successful Resuscitation**

As previously discussed, by allowing FMs to be present with a loved one during resuscitation, the patient is reunited with people from their own social context. During a crisis in which the patient struggles between life and death, being able to do something helped FMs feel they were able to contribute to the efforts of the resuscitation. Being present gave them something to do (Clark et al., 2005). Patterns of important actions by FMs included honoring the relationship with their loved one, advocating for their loved one, and being present at the time of death.

Study participants were able to touch the patient, talk to the patient, ask questions, and offer input into interventions. These actions helped FMs feel they contributed to the efforts to
restore life (Clark et al., 2005), being part of the team, and involved in the outcome (Clark et al., 2005). All participants in this study stated it was important for them to be in the room, to be with their loved one, to support and encourage their loved one, and to be involved in decisions regarding treatment. They also stated it was helpful to know that all possible action was taken. Every participant felt “everyone should be allowed to be present if they desire, but should not be required because some FMs might not be strong enough to handle it.”

**Educational Considerations**

As patient/family-centered care becomes more prevalent in the healthcare setting, nurses, physicians, ancillary staff, and chaplains need to receive education regarding therapeutic practices of FP during resuscitation. Researchers recommended that any staff participating in resuscitation events receive education regarding institutional FFPR policies and procedures. In addition to learning the procedures for the actual resuscitation, education on inviting FMs into the resuscitation area, therapeutic communication, and including them in the resuscitation should be part of the regular training. Education and training for an FF should include an overview of the interventions involved in resuscitation, therapeutic communication techniques including active-listening skills, assessment of FMs’ readiness to enter and exit the resuscitation area, knowledge of end-of-life religious and spiritual practices, and the ability to mediate difficult discussions.

**Recommendations for Future Research**

The practice of FFPR is relatively new in the healthcare setting; therefore, an array of opportunities exist to gain greater insight into the experiences of FMs present with a loved one during resuscitation. This study contributed research exploring the long-term effects of FFPR from a period greater than 3 months. Perhaps a year or more following the event would add
information about long-term effects of FFPR on FMs. An additional beneficial study would be to explore the experiences of FFs and their perceptions about assisting FMs in being present during resuscitation. Along the same lines, an exploration of the experiences and perceptions of the various members of the resuscitation teams regarding FMs being present during resuscitation would be valuable. Gaining more insight into the experiences of the various persons involved will provide greater insights into best practices and better educational foundations.

An aspect of the FFPR experience revealed during the analysis of the transcripts, but not addressed by the research questions for this study, is the aspect of ‘time-between’. For most of the participants of this study, there was an initial resuscitation event and then a life ending event, such as a decision to withdraw life-sustaining technologies, or a subsequent resuscitation event. The time-between the initial event and the life-ending event ranged from less than one day to seven days, with one having four months. The poignant moments of this time-between revolved around reconciliation of relationships, saying good-bye and end-of-life decision-making. Further exploration of the experience of the ‘time-between’ an initial CPR event and subsequent actions would provide helpful understanding about the needs of patients and family members during this time.

Another research focus includes the long-term effect of FFPR on FMs. Many participants who shared their experiences for this study commented at the end of the interview that it was helpful to talk about their experiences. The act of retelling, or the act of telling their story for the first time, became a moment of reconciliation and healing for some. Participant told their stories at least 3 months after the final resuscitation event. As grief-recovery theories suggest, at about 3 months post-event people begin moving into the stage of “disorganization” in which the reality of the loved one’s death is apparent and all of life changes (Sellers, 2013, pp. 1286–1287). One
aspect of this phase is the need to find meaning in the death of a loved one, and another is to figure out how to continue without that person in one’s life.

Retelling the story, as experienced by the storyteller, helps the person develop one’s public story. The public story is the story one develops to tell others about a traumatic event. In developing the public story, the process of recreating the story to make meaning and sense out of the death event for one’s own life assists the person in moving to the next phase of grieving. A participant in this study commented, “now that I am talking about it, I can see that he wasn’t responding to the CPR and that I didn’t end the CPR too early.” Others said it was good to talk about the experience, to help in processing the event. “Now that I am talking about it, I see different things than I did before.” Based on the timing of the interviews at 3 months following the event, a follow-up conversation about their experience seemed to be beneficial to the grief process. Further research regarding follow-up care for FMs who were present during resuscitation may be beneficial in providing therapeutic grief interventions thus promoting better mental health outcomes.

Summary

In health care today, technology is being developed to assist people to maintain their activities of daily living with incredibly clever inventions. Machines mimic a heart, a kidney, and lungs to sustain physiological function of a human body. Despite such technology, at times, the heart or body fails and cardiac arrest happens. To date, the primary intervention is primitive and violent in nature and considered the last effort to either restore life or ensure death. Offering FMs the opportunity to be with their loved one while undergoing the resuscitative efforts of CPR provides the basic need for connection with loved ones during life-threatening moments, and reconnects the family with the patient at time of death in the midst of chaos.
The practice of FFPR is beneficial for FM\s during and following the situation. Providing an FF to be present with the FM gives *guidance through a surreal and sacred time*, allowing the FM to be present and actively involved in supporting and encouraging the patient, and provides the opportunity to be involved in decision making. Allowing the FM to be present and involved is critical to the FM *contributing to a successful resuscitation*. The FM\s view of a successful resuscitation is being able to be present in honoring their relationship with the patient, advocating for the patient, and being present with the patient at time of death. An additional nuance related to the practice of FFPR includes the sense of surreal *time* and *sacred space* in which the time stands out as unreal, miraculous, tentative, and sacred in nature. The benefits of FFPR are evident in that all participants stated they would be present again, even though CPR is violent and traumatic, especially if it were the last time they would be able to see their loved one alive.
BIBLIOGRAPHY


Table I. DATA ANALYSIS AND MANAGEMENT USING A PHILOSOPHICAL HERMENEUTIC APPROACH

**Steps in analyzing text** (de-identified and line coded transcripts with self-selected pseudonyms)

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1) Read the transcript carefully, start to finish

2) Re-read the text line by line

3) Make notes about concepts or situations that stand out

4) Review notes and observe the general categories, noting frequency of related ideas, position in text, response to interview questions, style of response (halting, stuttering, slang, affect conveyed)

5) Devise rudimentary list of emerging patterns of ideas

6) Review transcripts with these general patterns in mind

7) Name patterns of ideas (using questions, phrases, dynamic activities)

8) Write a summary of the transcript with as much detail or support as time allows, including a retelling of the account and/or a description of emerging patterns, and/or interpretations, any or all with as much textual support (line references, exemplars) as time allows

These summaries will build with each transcript. After several transcript analyses, summaries, and interpretations will coalesce. As texts are read across one another and across summaries and interpretations, patterns will revise and naming themes will become part of the iterative process. During this process, repeated readings of transcripts and developing interpretations are done.

**Managing data**

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1) After several transcripts are analyzed, storage units using working themes (named pattern of ideas) are created using preferred software or paper files

2) Text is deconstructed according to working themes, noting areas of overlap

3) Verbatim, line-coded pieces of the transcript are chosen for their representation of the ideas/emerging categories identified in the interpretations

4) Excerpts (labeled by pseudonym and line locations) are placed into folders that exemplify or represent ideas signified by the working themes; excerpts may be placed in more than one folder

5) All written interpretations are collected and filed together as part of the multi-layered data that is “text”.
<table>
<thead>
<tr>
<th>Developing and presenting interpretations</th>
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<td>1) Use of a research team is employed when possible*</td>
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<td>2) As new transcripts are analyzed and when all transcripts are analyzed once, all written interpretations are reviewed.</td>
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<td>3) Storage units are reviewed in their entirety and considered against interpretations</td>
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<td>4) Patterns and themes are determined, always subject to revision, and final writing begins</td>
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<td>5) Written results include a summary and interpretation of each theme (I typically find two or three major themes that may subsume several subthemes; one or two overarching patterns may emerge from discussion or analysis).</td>
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*Research teams consist of methodological or content experts, professional, lay, or student readers who study the transcripts and/or the multi-layered text, providing written and/or verbal analytical or interpretive input.

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