FAMILY PRESENCE DURING RESUSCITAITON:

CHANGING THE AMERICAN PARADIGM

A dissertation submitted to Caspersen School of Graduate

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Doctor of Medical Humanities

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ABSTRACT

FAMILY PRESENCE DURING RESUSCITATION:

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DMH Dissertation by

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The practice, known as "Family Presence During Resuscitation" (FPDR), allows one or two family member in the resuscitation room to observe the life-saving measures performed by the rescue team. Although twenty-seven years of previous research has shown there are many positive aspects of FPDR, it remains controversial and has not yet become the standard of practice in most hospitals. The majority of research in the field of FPDR has involved healthcare professionals, not the general public.

Families should have the opportunity to choose whether or not they wish to be present during resuscitation. FPDR should not only be a decision of the physician managing the resuscitation, but an informed autonomous one with the family. The ethical concepts of this study include beneficence, paternalism, and autonomy in determining what is optimal for the patient and their families in FPDR. Bridging the gap of misconception, technological advances and newer ethical applications provide a foundation for further discussion of FPDR.

The purpose of this study was to determine if factual information, retrieved from previous research studies regarding FPDR, positively influences the perceptions of the adult lay-pubic in the United States. The original self-administered survey retrieved a

convenience sample of 443 lay-public respondents and tested their knowledge and perceptions of the practice of FPDR. Respondents were given pretest questions, then provided factual information and post-tested using the same questions to identify changes in their thinking about FPDR. Results suggest that the public will transform their thinking and perceptions of FPDR when provided factual information. More specifically, the respondents that; experienced family death, were present for a family death, or made their end-of-life wishes known are more likely to choose to be present during resuscitation. Those respondents who had been present at a family death showed the most statistical significance out of the three areas of life experience.

When the public becomes more informed on the topic, their interest in attending FPDR will be more positive and decision-making more autonomous. The outcomes achieved in this research further substantiate the need for more education in the topic of FPDR, especially the lay-public.

DEDICATION

To my husband and sons for their patience, humor, love, and support.

Craig, Peter, and Dan.

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with their expertise and time.

Phyllis DeJessse, D.M.H., RN

and

Margaret Micchelli, Ph.D

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INTRODUCTION

Today, medical centers are embracing the concept of Evidenced-Based Practice (EBP) to improve patient care delivery through comprehensive research and best practice models. "Practicing from an evidenced-based paradigm requires the practitioner to integrate best available evidence with the patient's preferences and values, the clinical context, and the practitioner's clinical expertise."[1] The Evidenced-Based approach requires the practitioner to ask continually whether there is a better approach to delivering patient care.[2] Use of the EBP model consistently seeks current research to better serve the patient, family, and institution.

Another popular concept in today's healthcare is the involvement of patients and their families through a family-centered care model.[3] Including the full continuum of care has been paramount to the topics of improved patient care and patient autonomy. For example, today, fathers are not only welcomed into the delivery room, but also expected. Families are encouraged to stay with their loved one's during their final days of life through hospice programs. Healthcare institutions must remain diligent in their practices of delivering the finest care to their patients and families. Optimal healthcare includes the participation of patients and their families in many of the most important decisions surrounding their care, including end-of-life.

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[1] Susan W. Salmond, "Finding the Evidence to Support Evidenced-Based Practice," Orthopaedic Nursing 32, no.1 (January/February 2013): 16-22.

[2] Salmond, 16.

[3] Institute for Family-Centered Care, "Advancing the Practices of Patient and Family-Centered Care," http://www.health.gov.sk.ca/advancing-pfcc. html. (accessed October 20, 2013).

Historically, when a hospitalized patient suffered cardiopulmonary arrest, the family was rapidly escorted away from the patient into an isolated waiting area. The "code team"[4] would rush to the bedside and attempt to resuscitate the patient while the family anxiously awaited the outcome of the resuscitation efforts. An opportunity for family members to remain with their loved ones during resuscitation has emerged in the last twenty-five to thirty years. The practice, known as "Family Presence During Resuscitation" (FPDR), allows one or two family members to observe the life-saving measures performed by the rescue team. Family presence allows the family to touch the patient and to be physically present for their loved one during the code team's life-saving efforts. FPDR is a controversial hospital practice issue that continues to generate debate in the medical community.[5]

Individual hospitals make decisions regarding FPDR through formal policies, specific to each hospital. A hospital team that wishes to incorporate a policy to encourage FPDR usually begins the process through the education of the staff nurses, physicians, and respiratory therapists. Many of the research studies done in hospitals that involve FPDR are performed to introduce the code team to the issues surrounding FPDR and expose them to the research findings. These efforts are often used to persuade the code

[4] Code team is the term used to identify a group of doctors, nurses, and respiratory therapists that have been trained in ACLS and are assigned to attend all respiratory or cardiac arrests to perform life-saving procedures.

[5] Margo A. Halm, "Family Presence During Resuscitation: A Critical Review of the Literature," *American Journal of Critical Care* 14, no. 6 (November 2005): 494.

team and other hospital personnel to accept a new hospital policy regarding the use of FPDR.[6] No education is required to be given to the patients and their families.

End-of-life decisions are often planned using a legal document called an Advance Directive. An Advance Directive is a document where a person formalizes their healthcare decisions in the event that, in the future, he/she becomes unable to make those decisions. Unfortunately, the Advance Directive does not consider or address the concept of FPDR. Most persons are not even aware that there is an opportunity to be present during their loved one's resuscitation.

I will argue that change in the national standard of care regarding FPDR will emerge only through public awareness, the consumer's demand for a change in our hospital practices, and continued awareness through education of the public and healthcare personnel. This dissertation will study the general public's knowledge and perceptions of FPDR and provide current research findings pertaining to FPDR. My assumption is that the information provided to the respondents will positively affect the participant's future decision making, both as a patient and as a family member. Providing factual information based on previous research allows patients and their families an opportunity to make a more informed autonomous decision regarding their view on the topic of FPDR.

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[6] Roberta Basol, Kathleen Ohman, Joyce Simones and Kirsten Skillings, "Using Research to Determine Support for a Policy on Family Presence During Resuscitation," *Dimensions of Critical Care Nursing* 28, no. 5 (September/October 2009): 237-47; Janice A. Mangurten, Shari H. Scott, Cathie Guzzetta, Jenny S. Sperry, Lori A. Vinson, Barry A. Hicks, Douglas G. Watts, and Susan M. Scott, "Family Presence: Making Room," *America Journal of Nursing* 105, no. 5 (May 2005); Patricia Mian, Susan Warchal, Susan Whitney, Joan Fitzmaurice, and David Tancredi, "Impact of a Multifaceted Intervention on Nurses' and Physicians' Attitudes and Behaviors Toward Family Presence During Resuscitation," *Critical Care Nurse* 27, no. 1 (February 2007).

The purpose of this study is to determine if factual information, retrieved from previous research studies regarding FPDR, positively influences the perceptions of adults in the United States. This quantitative research study focuses on adults in the general public only, not healthcare personnel.[7] Each respondent was given a demographic questionnaire, seventeen survey questions, followed by a short educational paragraph regarding the process of resuscitation and facts about researched responses to FPDR. All of the participants were given a post survey with the same seventeen questions to identify changes in their responses based upon the factual information given to them. The survey data was analyzed by using a t-test and chi-square to identify statistical significance.

Some of the long-standing issues surrounding FPDR have been based upon perception, not fact. Staff members were fearful that family members would become too emotional and disrupt the resuscitation. Medical staff were also concerned that family presence would increase the legal risks to the code team.[8] Subsequent research has shown these perceptions to be unsubstantiated.[9] "The emotional arguments unsupported by data that have been used to ban families from the bedside are being replaced by cumulative,

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[7] The majority of the FPDR research has been done with hospital staff, not the lay-public. Halm, 2005.

[8] Constance J. Doyle, Hank Post, Richard E. Burney, John Maino, Marcie Keefe, and Kenneth J. Rhee, "Family Participation During Resuscitation: An Option,"*Annals of Emergency Medicine* 16, no. 6 (June 1987): 673-75.

[9] Doyle et al., Cheryl Hanson and Donna Strawser, "Family Presence During Cardiopulmonary Resuscitation: Foote Hospital Emergency Department's Nine Year Perspective," *Journal of Emergency Nursing* 18, no. 2 (April 1992): 104-6.

consistent positive findings generated from a growing number of family presence studies."[10]

Constance Doyle, MD and a small group of colleagues performed the first FPDR research study of its kind in an emergency room at Foote Hospital in Jackson, Michigan, 1987. They discovered a need for change in their emergency room:

> We began to question the fairness of a policy to exclude close family members from the treatment room during attempted resuscitation of cardiac arrest victims in 1982 after 13 of 18 surviving relatives (72%) who were surveyed about their experiences during the attempted resuscitation of a family member responded that they would have liked to have been present during the resuscitation.[11]

In 1982, the Doyle research team began a program of planned participation of family members who would be allowed in the resuscitation room. The interdisciplinary research team research team included a hospital chaplain, a small group of emergency room physicians, and nurses. Following seventy FPDR episodes, the families were mailed a survey to solicit feedback for the research and code team:

> All of the respondents reported that they felt the medical and nursing staff had done all that could have been done."[12] "Forty-four of the 47 respondents (94%) thought they would participate again. Eighteen (35%) emphatically asserted their right to be present with a dying relative. Thirty-six (76%) believed that the adjustment to the death, as well as their grieving was made easier. Thirty (64%) believed that their presence was beneficial to the dying family member.[13]

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[10] Dezra J. Eichhorn, Theresa A. Meyers, Cathie Guzzetta, Angela Clark, Jorie D. Klein, Ellen Taliaferro, and Amy O. Calvin, "Family Presence During Invasive Procedures and Resuscitation: Hearing the Voice of the Patient," *American Journal of Nursing*" 101, no. 5 (May 2001): 48-55.

[11] Doyle et al., 673.

[12] Doyle et al., 674.

[13] Doyle et al., 674.

Following the Doyle study, two of the emergency room nurses at the same hospital decided to continue the research spanning the next five years.[14] Their findings replicated the results in the Doyle study and further confirmed the need for FPDR. "With nine years of experience in facilitating acceptance of death and grieving by this method, it is hard for us to understand that this practice is seldom considered . . . we continue to find it [FPDR] a humanizing, workable experience."[15]

To this day, researchers refer to this groundbreaking work of Doyle in the field of FPDR that promotes family presence. Subsequent research work in the adult setting has been primarily done at the descriptive level.[16] The majority of the FPDR studies have been conducted through the use of the survey tool. "Limitations of these designs include small convenience samples, low response rates, use of retrospective surveys with the strong possibility of bias, and a lack of consistency in the survey instruments."[17] These factors make the comparison of findings between studies more difficult. Patient or family research in the field of FPDR is very limited and often-qualitative studies are done. Many of the research studies for FPDR have been launched in an effort to persuade hospital staff to participate in FPDR through the use of hospital protocols. Research in the field of public perception or ideas regarding FPDR is very limited.

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[14] Hanson and Strawser, 104-107.

[15] Hanson and Strawser, 106.

[16] Halm, 494.

[17] Halm, 494.

Less than five percent of the hospitals in the United States have written policies that allow families into the room during resuscitation.[18] Endorsing the practice of FPDR has been found in most of the research studies over the last twenty-five years. The practice of FPDR is not yet the standard of practice in most hospitals, despite the recommendations obtained through numerous research findings. The growing numbers of FPDR studies are offering "cumulative, consistent positive findings, generated from a growing number of family presence studies."[19]

Most patients and family members are not aware of the opportunity for participation in FPDR. The physician or code team leader primarily makes the decision for family presence, without input by the patient or family. "Temptations arise in health care for physicians and other professionals to foster or perpetuate patients' dependency, rather than to promote their autonomy"[20]

Chapter One of the dissertation reviews the literature of FPDR beginning with the original study of Constance Doyle in 1986. The Doyle et.al. study continues to be considered the comparative study in most of the FPDR literature. The conclusion reached in this initial FPDR study states, "[o]ur findings suggest that a policy of routinely denying access to a dying patient may not meet the legitimate needs of the grieving

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[18] Susan L. MacLean, Cathie E. Guzzetta, Cheri White, Dorrie Fontaine, Dezra Eichhorn, Theresa A. Meyers, and Pierre Desy, "Family Presence During Cardiopulmonary Resuscitation and Invasive Procedures: Practices of Critical Care and Emergency Nurses," *America Journal of Critical Care* 12, no. 3 (May 2003): 246.

[19] Eichhorn et al., 55.

[20] Tom L. Beauchamp, and James F. Childress. *Principles of Biomedical Ethics*. 6th ed. (New York: Oxford University Press, 2009): 104.

family."[21] Further study outcomes suggest there is no reason to keep families away from the patient during resuscitation.[22] The literature review is comprised of studies on the topic of FPDR and does not include the presence of family during invasive procedures. Adults were the focus of the study and, therefore, no pediatric studies were reviewed. FPDR has been more of an accepted practice in the emergency room, but FPDR is very limited in the rest of the hospital environment. Themes occurring in the literature that support FPDR include: being comforted, receiving help, reminder of personhood, maintaining family connectedness, FPDR is a right, and the family begins to understand the severity of the situation.[23]

Chapter Two illustrates the ethical principles chosen for the basis of this research study. The principles that are examined in the FPDR research include: beneficence, "beneficence–in-trust," paternalism, and autonomy. Informed autonomous decision-making better describes a more realistic and mutually beneficial relationship between the physician, patient, and family. [24] As a consumer, the patient and the family have to become more knowledgeable in healthcare and medical matters. Medicine has become more technical and complicated and the relationship between the doctor and the patient more limited. Physicians' roles are is rapidly changing because of the transient nature of many patients, specialization of medicine, patients demanding more participation in decision-making, and the increasingly litigious nature of medicine. Unfortunately,

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[21] Doyle et al., 675.

[22] Doyle et al., 675.

[23] Eichhorn, et al., 48.

[24] Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988): 54.

physicians are forced to practice defensive medicine that seeks to protect the physician and institution rather than protecting the patient. Understanding the importance of ethical principles in decision-making will ultimately benefit all the participants in the resuscitative process, including family and their loved ones.

Chapter Three outlines the methodology of this research by using a self-administered experimental quantitative pretest – posttest research tool. The questionnaire is an original tool. Questions were based on the literature review, previous research outcomes, and recommendations created for future research. Respondents in this study were drawn from three different sources; one Midwest college of undergraduates, an East coast undergraduate and graduate school, and Survey Monkey. All of the participants were given the same tool online with seventeen survey questions, then read an educational paragraph on FPDR, and retook the same seventeen questions. This process will allow a better understanding of the effects of education on the changes in the participants' thinking and perception. There are five research questions for the basis of this study:

1. Do different demographic groupings have different perceptions concerning FPDR?
2. Does factual information regarding resuscitation influence the general public's perception concerning FPDR?
3. Does life experience, such as experiencing a loved one's death, influence the general public's perception of FPDR?
4. Does life experience, such as being present at a loved one's death, influence the general public's perception of FPDR?
5. Does end-of-life planning influence the general public's perception of FPDR?

Survey questions include demographic information and the responses based upon the participant's experience with death, attendance at a loved one's death, and the opportunity to make their end-of life wishes known to others. Through the educational

process, the respondent will become more informed on the topic of FPDR and be able to make more autonomous decisions in their healthcare.

Chapter Four presents the data from the survey, which is divided into five sections. The opening section identifies basic information, such as the percent of completed surveys, method of survey retrieval, and process of analyzing the data. The second section summarizes the "average" characteristics of the participants as it is reported from the demographic selections. Section three presents a statistical comparison between each participant's presurvey and postsurvey. This portion reports the actual changes in the participant's perceptions and thoughts surrounding FPDR. The final section analyzes the responses based upon the participants' life experience as it pertains to the demographics and the seventeen survey questions. Life experience questions are answered by a simple yes or no.

Education of the public on the topic of FPDR will change the standard of practice in our healthcare institutions. Greater knowledge for the patient and family will demand the opportunity to participate in the decisions of FPDR. Ignoring the family and their needs at the time of their loved ones resuscitation will only perpetuate a history of paternalistic decision-making and negative perceptions of family participation.

If we are committed to EBP, family-centered care and family participation in the decision-making processes, we must remain diligent in the education, rights, and responsibilities of FPDR. Patient autonomy and its extension to the family are of vital importance at the end-of-life. Healthcare professionals have an obligation to educate the patients and assist their loved ones in an understanding of the severity of the patient's illness, the importance of touch, grieving and observing life-saving procedures during

FPDR. All of these findings are based upon positive outcomes from previous research on the topic of FPDR. When the public becomes more informed on the topic, their interest in attending FPDR will be more positive and decision-making more autonomous.

The first chapter describes various research studies that have been done in the United States over the last twenty-five plus years. The literature review examines the various research methods on the topic of FPDR as it pertains to the adult patient and the outcomes achieved in each study.

CHAPTER 1

REVIEW OF LITERATURE

The review will focus on the studies of FPDR that involve an adult who is resuscitated in a hospital setting in the United States. Many of the researchers have identified some of their own limitations and make recommendations for future study to enhance the FPDR research field.

"Most FPDR research in the adult setting has been primarily at the descriptive level."[25] The majority of the FPDR studies have been conducted through the use of the survey tool. Limitations of these designs included small convenience samples, low response rates, use of retrospective surveys with the strong possibility of bias, and a lack of consistency in the survey instruments.[26] These factors made the comparison of findings between studies more difficult.

The literature review begins with the first research study done in the field of FPDR by a small group of physicians in an emergency room (ER) at Foote Hospital in Jackson, Michigan, 1987.[27] This study was known as the Doyle et al. study, which became the cornerstone for all other FPDR studies that followed over the next twenty-five years. The Doyle et al. study was done after the healthcare team at Foote Hospital

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[25] Margo A. Halm, "Family Presence During Resuscitation: A Critical Review of the Literature," *American Journal of Critical Care* 14, no. 6 (November 2005): 495.

[26] Halm, 494.

[27] Constance J. Doyle, Hank Post, Richard E. Burney, John Maino, Marcie Keefe, and Kenneth J. Rhee, "Family Participation During Resuscitation: An Option," *Annals of Emergency Medicine* 16, no. 6 (June 1987): 673-75.

had questioned their long-held rule not to allow family into the resuscitation room.[28] The code team believed the old rule was unfair to families. On several occasions, family members requested to be with their loved one during the resuscitative process and were denied access. Two particular situations prompted the code team to reassess the hospital rule to keep the family out of the room for resuscitation. The first situation involved a spouse, who rode in the ambulance with her unresponsive husband. Once they arrived at the ER where he required resuscitation, she refused to leave his side and consequently, was allowed to remain with him throughout the resuscitation. The second scenario included the wife of a police officer who had been shot in the line of duty. She pleaded with the ER staff to remain at her husband's side during his resuscitation and she was granted that opportunity. The study did not clarify for the reader whether or not either of the resuscitative attempts were successful. Nonetheless, comments made by the women and the code teams' own observations led them to conclude that, in these two instances, FPDR appeared to be beneficial to the wives. As a result, the ER staff slowly began to allow more FPDR, beginning as early as 1982. Families were asked if they wished to be present during resuscitation and if the answer was affirmative, the chaplain or a nursing staff member from the ER briefed them on the code process before entering the code room. Hospital staff was sensitive to the needs of the family and tried to accommodate

[28] The term resuscitation room or code room describes the location of the patient at the time of their respiratory or cardiac arrest, which is usually in their own hospital room. Sometimes the arrest can occur in a patient bathroom, hallway, or special procedures department. There is no actual or specific code room.

those needs through good communication, sharing information, and supporting the family during the emergency.[29]

The ER staff of physicians and nurses decided to formalize a study of FPDR, through a retrospective survey of the families that were allowed to be present during their loved one's resuscitation.[30] All the patients had either died in the ER or later in the intensive care unit (ICU) after transfer from the ER. Surveys were mailed approximately four months after the death of the family member; family members were asked to complete a survey on their FPDR experience.[31] This was the first survey of its kind in the study of FPDR:

> A survey was sent to 70 family members who had attended a resuscitation during the first six months of 1985… Forty-four of 47 respondents (94%) thought they would participate again. Eighteen (35%) emphatically asserted their rights to be present with a dying relative. Thirty-six (76%) believed that the adjustment to the death, as well as their grieving was made easier. Thirty (64%) believed that their presence was beneficial to the dying family member.[32]

Surveys from some family members included comments such as "I couldn't imagine not being part of it" another remarked that FPDR "allowed them to say good-bye."[33] The father of a teenage boy, who had sustained a severe head injury from an accident, stated, "I feel that he knew that I was there. He seemed to calm down when he

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[29] Doyle et al., 673.

[30] Doyle et al., 674.

[31] The researchers carefully selected the families that were mailed a questionnaire, avoiding situations such as a murder case that posed a possible medical-legal problem. When patient injuries were excessively gruesome, the researchers also chose to exclude these families.

[32] Doyle et al., 674.

[33] Doyle et al., 674.

heard my voice and let the doctors help him."[34] Other families commented that they felt the resuscitated family member knew they were present for them. Many of the families expressed that they were comforted in knowing that everything possible was done.[35]

Additionally," twenty-one ER staff members" were also surveyed regarding their attitudes following FPDR to determine whether or not they felt the family interfered with the resuscitative process.[36]

> Seventeen of 21 (81%) reported being present during family participation in the resuscitation room. Six of 20 (30%) reported being hampered in their activities, mainly by anxiety about their performance in view of others or by concerns about possible emotional or disruptive behavior on the part of the family. Nevertheless, 15 of 21 (71%) endorsed the practice of family participation. The staff reported increased stress associated with resuscitation, because the patient being resuscitated seemed "more human" in the presence of family members.[37]

As a longtime code team member, I have often observed that the code process becomes a very mechanical procedure; the team forgets that they are working with a living human being and are simply following a very prescriptive cardiopulmonary algorithm. The presence of family members offers a more human approach by personalizing the patient to the code team.

Data from the Doyle study confirmed that the majority of the ER staff at Foote Hospital believed the old rule forbidding FPDR was outdated and did not adequately serve the best interest of the families and perhaps the patient.[38] Not all family members

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[34] Doyle et al., 674.

[35] Doyle et al., 674.

[36] Doyle et al., 674.

[37] Doyle et al., 674.

[38] Doyle et al., 675.

wanted to be present in the code, but the staff believed that families should, at the very least, be afforded the opportunity. Most of the ER staff, "seventy-one percent," believed that families should not be excluded from the resuscitation process, if they wish to be present.[39]

The code team entered the research process with sensitivity and the right intention of researching the practice that had already begun at Foote Hospital.[40] The purpose of the retrospective, descriptive research study was to determine attitudes of the staff and patients' families toward FPDR. One of the greatest strengths of the study was the inclusion of both the family and the staff perspectives of FPDR. The qualitative portion of the study provided individual opinion from the participants, which further enhanced the groups' quantitative data. Research questions that were given to the staff or to the families were not provided in the publication; therefore, the reader is unable to discern if there was any bias in the questions or could not evaluate the content of the questions. Doyle et al. did not discuss the particular development of the study questions and did not report on the reliability or validity of the research questions. Those that read the study had to depend solely on the interpretation of the data by the authors, without an opportunity to scrutinize the findings independently.

Doyle et al. concluded that a policy of "routinely denying access to a dying patient may not meet the legitimate needs of the grieving family."[41] The outcome of the study suggested that there is no reason to keep families away from the patient during

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[39] Doyle et al., 675.

[40] Doyle et al., 675.

[41] Doyle et al., 675.

resuscitation. Conclusions may be valid but caution should be taken that the small sample size may cause an over-interpretation of the limited data.

Participants in the code team for this first study of FPDR should be commended for their progressiveness in viewing the need to change old rules to suit the shifting needs of society. All too often, hospital staff may be more concerned about their personal needs and overlook the needs of the family. For some hospital staff, it is less emotional to remain detached and easier for them not to include the family.

Two emergency room nurses, Hanson and Strawser who were part of the original Doyle study, continued their own research in the same setting at Foote Hospital.[42] The Hanson and Strawser research study was designed to measure outcomes of FPDR over an extended period of nine years, either to affirm or refute the findings of the Doyle study. Initially, as with the Doyle study, staff members feared that family members would suffer from uncontrollable grief and disrupt the code team. The code team also feared their own emotions might be too strongly evoked by the grieving families. Another concern was that family presence and observation would increase the hospital and code teams' legal risk during resuscitation.[43] During the nine years of the Hanson and Strawser research program, none of these fears materialized into major problems. In fact, not one experience of interference occurred during the resuscitative activities. FPDR practice is now accepted widely and expected participation both from the ER staff and by the community at Foote Hospital.

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[42] Cheryl Hanson and Donna Strawser, "Family Presence During Cardiopulmonary Resuscitation: Foote Hospital Emergency Department's Nine Year Perspective," *Journal of Emergency Nursing* 18, no. 2 (April 1992): 104-6.

[43] Hanson and Strawser, 104.

The general reaction of the families and the staff to FPDR was positive. Many of the families expressed similar needs, such as the need: 1) to remain with the dying person, 2) to be kept informed, and 3) to know that the dying person was not in pain.[44] Staff continues to find FPDR a "humanizing, workable experience."[45] Hanson and Strawser did not find any new evidence during the continued research of Doyle et al. study, but were able to further substantiate the previous findings that Doyle et al. had generated.

During the mid 1990s, two particular foreign studies in FPDR were done. The first of these was Chalk (1995), who created a descriptive study that explored the attitudes of ER professionals toward FPDR in the United Kingdom.[46] In this study, a survey was distributed randomly to "fifty nursing, physician, and ambulance staff members" from several area hospitals in London.[47] Respondents were given eight questions to identify their attitudes toward FPDR with a reply choice of "yes," no," or "don't know."[48] "Sixty-eight percent" of the staff felt that relatives should be given the choice to be in the resuscitation room; the vast majority of those in favor were nurses. The survey showed that nurses were more willing than physicians to allow FPDR, which was similar to the findings in Doyle et al. and Hanson and Strawser studies.[49]

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[44] Hanson and Strawser, 105.

[45] Hanson and Strawser, 106.

[46] Amanda Chalk, "Should Relatives Be Present in the Resuscitation Room?" *Accident and Emergency Nursing* 3 (1995): 58-61.

[47] Chalk, 60.

[48] Chalk, 60.

"Sixty percent" of the staff in the Chalk study had already allowed family presence during resuscitation.[50] The majority of the staff members allowed FPDR, if the families were well informed and accompanied by a supplementary staff member. The additional staff member could be a clinical or pastoral person who could devote his or her attention to the family and their immediate needs and questions. Almost half of those surveyed, who had experienced FPDR, would do it again. Some of the participants wrote comments regarding their hesitation toward FPDR. One of the Sisters participating in the study stated:

> Ideally, there should be a room, separated from the resuscitation room by a two-way mirror with one-way sound, which could be switched off. This would allow relatives to see and hear the full procedure but still be able to express their feelings without feeling compromised.[51]

Unfortunately, the Sister overlooked one of the most important reasons for allowing the family into the resuscitation room. Family and patients need the sense of physical presence and the warmth of touch, which cannot be done behind an observation window.

At the end of the study, the authors presented several recommendations for other hospitals planning to implement FPDR such as: 1) identify appropriate situations to allow families in the resuscitation room, i.e. describe situations that would fit the hospital criteria for FPDR, 2) decide whether or not to allow family participation based upon their request only, rather than to offer them the opportunity, 3) determine whether or not the code team members must all be in agreement with FPDR, and 4) ensure that the hospital

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[49] Chalk, 61.

[50] Chalk, 61.

[51] Chalk, 61.

provides a qualified person such as another nurse, chaplain, or social worker to remain with the family at all times during the resuscitation.[52]

Although the recommendations given in the Chalk study may be helpful for others beginning a FPDR program, I believe some of them recommendations lack understanding of resource availability. In an age of short staffing, providing additional staff members to stay with the family during resuscitation may not be a realistic recommendation. Oftentimes, resuscitative efforts can last longer than an hour and require more personnel time following the death of the patient. Also, the Chalk study recommended that only family members who have specifically requested FPDR be allowed in the resuscitation room.[53] This is not fair to other families who do not know that their presence in the code room is even a possibility. We cannot allow some families to participate in FPDR and turn away others based upon their knowledge of hospital procedure.

Two of the greatest strengths of this study were the unusual "response rate of 100%" by the staff and the variation of samples drawn from several different hospitals, albeit the respondent sample was small.[54] The study and its controversial questions stimulated many discussions by those that participated in the study as well as others with curiosity about FPDR. Bringing attention to the topic of FPDR is the first step to changing a policy and a hospital culture. Although the Chalk study had mostly strengths,

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[52] Chalk, 61.

[53] Chalk, 61.

[54] Chalk, 60.

the limitations of the study were the small sample size and the lack of description of the procedure or survey development.

In the year following the Chalk study, an Australian pair of critical care nursing specialists, Redley and Hood did another study patterned after the original Foote Hospital study.[55] The research objective was to recognize staff attitudes and concerns regarding FPDR and to determine the ER staff's willingness to consider FPDR as a new policy. Redley and Hood's objectives were very similar to the previous studies as we begin to see a trend in the research. Many of the studies sought data from a singular institution in an effort to implement a FPDR policy and procedure without adding any new information to the FPDR research findings. Redley and Hood wanted to find out what the staff's actual concerns were and to further the discussion of FPDR. A questionnaire was distributed to six metropolitan Australian hospitals.[56] Comments by those opposing FPDR were similar to previous studies but added more specific concerns from the staff such as:

- Staff disruption
- Interference with the treatment intervention
- Procedure may offend the families
- Staff may offend the family
- General public is not equipped to deal with being present during resuscitation
- Family members have no right to be present during resuscitation

[55] B. Redley and K. Hood, "Staff Attitudes Towards Family Presence During Resuscitation," *Accident and Emergency Nursing* 4 (1996): 145-51.

[56] The response rate was eighty-three percent with 133 questionnaires completed. Sixty–two percent of the participants indicated they would consider FPDR; fourteen percent believed that family members should always be allowed in the resuscitation room; eleven percent were opposed to FPDR; nine percent believed that the decision should be made by the medical person in charge of the resuscitation; and twenty-five percent were simply unsure about FPDR.

- No benefit to be gained by family presence
- Legal proceedings may arise from their presence[57]

Although previous studies raised several of these concerns, Redley and Hood discussed the code team member's specific discomfort with offending families during the resuscitation. My personal code team experience witnessed the use of offensive language in frustration or inappropriate humor to ease the stress and intensity of the code room. Families were very sensitive toward the behaviors of the code team and vividly remember details of their experience.[58] Redley and Hood suggested caution to the code team members to guard against inadvertent, unsuitable behavior during resuscitation; it can have far –reaching effects upon the family.[59]

The contributions of the Redley and Hood study are limited. Many of their findings have been substantiated in past studies. Perhaps the single major contribution was presented in the discussion of the code team discomfort with FPDR and the possible effects it may have upon the family. The strength of the research was in its large multidisciplinary sample from six different Australian hospitals providing varied quantitative data. There were no distinctions made between the various hospitals to discern differences in working-environment or the possibility of bias. Also, no report of

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[57] Redley and Hood, 148.

[58] Redley and Hood, 150.

[59] Redley and Hood, 149.

any sample description, survey development, reliability or validity testing was presented.[60]

During 1997, two more studies were added to the FPDR research. Similar to the purpose of the Redley and Hood study, nurses Belanger and Reed surveyed staff members to pre-test and introduce protocols for FPDR in their small Ohio hospital.[61] Unique to this study, the ER staff was given a pre-test survey to ascertain their personal experience and beliefs regarding FPDR, followed by a post-survey given one-year after the introduction of the FPDR protocols.[62] The year after the protocol implementation "88.9% of the staff " became proponents of FPDR.[63] Education and experience of the staff significantly impacted their comfort level with and positive responses toward FPDR. One of the skeptical physicians commented, "I was very much against FWR when we started. Now that I have seen the benefits to families and staff, I endorse it strongly."[64] Another staff member in the ER commented, "families are with hospice patients until the end . . . why should we prevent them from being there in a cardiac emergency?"[65] Belanger and Reed noted that the atmosphere of codes became more personal and staff members developed an increased awareness of each other's feelings. After twenty-four

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[60] Edwin D. Boudreaux, Jennifer L. Francis, and Tommy Loyacano, "Family Presence During Invasive Procedures in the Emergency Department: A Critical Review and Suggestions for Future Research," *Annals of Emergency Medicine* 40, no. 2 (August 2002): 199.

[61] Mary Anne Belanger and Sandra Reed, "A Rural Community Hospital's Experience With Family-Witnessed Resuscitation," *Journal of Emergency Nursing* 23, no. 3 (June 1997): 238-9.

[62] Forty-nine of ninety staff members responded to the pretrial survey. Fifty-six percent believed that families should be given the option to be present during resuscitation. FWR is the acronym for Family Witnessed Resuscitation used interchangeably with FPDR.

[63] Belanger and Reed, 239.

[64] Belanger and Reed, 239.

[65] Belanger and Reed, 239.

families had participated in the initial FPDR trial, the same families were surveyed again using a modified questionnaire from the Doyle et al. study. "One hundred percent of the families responded. Moreover, they unanimously believed that FPDR enabled them to cope better with their grief."[66]

Belanger and Reed had experience in the resuscitation process and also had experience with the presence of families during resuscitation. One of the incidents they recalled in the closing of their research article expresses a very poignant experience in the ER:

> A recent situation involved a 60-year-old man who arrived with symptoms of a massive myocardial infarction and had a cardiac arrest in the emergency department. The wife was present during the defibrillation. After several shocks, he regained consciousness long enough to speak with his wife momentarily until he again went into ventricular fibrillation. The code continued with his wife at his bedside whispering words of encouragement. Within minutes, he again regained consciousness. Anticoagulation was initiated and he was transferred to the critical care unit. A few days later he was interviewed by an emergency room nurse and stated he was very much aware of his wife's presence, which was enough of an encouragement for him to continue his fight for survival.[67]

The importance of the Belanger and Reed study demonstrated how professional experience and written protocols can have a positive effect upon the staff's acceptance of FPDR. Families, who experienced FPDR, responded positively to their opportunity to be with their loved one at the time of resuscitation. Although this study was limited in size and its venue was a small rural hospital, the study further substantiated previous research. The Belanger and Reed study validated that the recommended FPDR protocols can be utilized successfully in a small community hospital as effectively as in a large

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[66] Belanger and Reed, 239.

[67] Belanger and Reed, 239.

metropolitan setting. Comments and specific patient and family reactions provided a more human and less technical approach to the research topic. Major limitations in this study were similar to the previous research studies regarding reliability and validity.

Stefan Timmermans took a different approach in the study of FPDR involving his own theory to define the levels of staff acceptance to FPDR. Timmermans, a sociologist from Brandeis University, used a quantitative approach to assess responses and perceptions of FPDR. The goal of Timmermans' research was to determine what conditions prompt change and allow a new policy such as FPDR to be implemented. Timmermans constructed the argument that a new policy of FPDR will be accepted only when health care providers shift their perceptions surrounding the process of resuscitation; that is, changing the view of resuscitation from a prescribed clinical algorithm to a more holistic viewpoint that included the needs of the family.[68] Timmermans performed "fifty-seven interviews" with health care providers in 1997.[69] He interviewed "eleven physicians, nineteen nurses, three nursing supervisors, seven respiratory therapists, nine emergency room technicians, two social workers, and six chaplains from four different hospital ERs."[70] The interviews were done in four Midwest US hospitals and one hospital in Belgium. Interviews consisted of fifteen semi-structured questions inquiring about opinions of the staff regarding FPDR.[71]

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[68] Stefan Timmermans, "High Touch in High Tech: The Presence of Relatives and Friends During Resuscitative Efforts," *Scholarly Inquiry for Nursing Practice: An International Journal* 11, no. 2 (1997): 153-68.

[69] Timmermans, 154.

[70] Timmermans, 154.

[71] Timmermans, 154.

Timmermans divided the FPDR interview responses into three different categories for discussion. These categories differentiate staff opinions, experience, and philosophical ideas of FPDR. Category one contains the persons who advocate for what Timmermans refers to as the "survival perspective."[72] The "survival perspective" group maintained their only goal in resuscitation should be to save a human life. This view was based upon a set of clinical interventions or algorithms that could reverse sudden death or cardiac arrest. The uninterrupted flow of the resuscitative protocols was a very important aspect in the success of the resuscitative effort. Therefore, this group did not believe FPDR to be appropriate in meeting their goal.

Timmermans believed the "survival perspective" was more common among less experienced or uncertain healthcare professionals. Less experienced code team members may feel more insecure about their abilities in an emergency situation; having family present may intimidate or cause further stress to their performance. The "survival perspective" viewpoint may consider FPDR as an interference, which causes the code team to lose focus upon the patient. A nurse whose opinion would be described as a "survival perspective" commented about FPDR:

> We certainly don't ever want to make mistakes in front of a family member. You mix up the drug boxes sometimes. Sometimes you forget to take off the tourniquet . . . sometimes these things happen. You don't want to ever have a family see you make a mistake in resuscitation. For the family member this is just terrible. You don't want to have something go wrong –an IV gets pulled our accidentally. You say: "Oh shit." You can't do that with a family member sitting there, and you want to be free to be able to do these things. And I think that we don't want somebody standing there being . . . having the opportunity to be judgmental of us.[73]

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[72] Timmermans, 157.

[73] Timmermans, 158.

This quotation by a code nurse described those code team members that ascribe to the "survival perspective" of Timmermans.

Timmermans referred to the second category of respondents in the study as the "bifurcated perspective."[74] This group believed that resuscitation has two goals, "saving lives and taking care of the family's needs."[75] "These two goals implied a division of labor."[76] The code team attended to the patient and the chaplain or social worker stays with the family or significant other in an area of the hospital other than the code room. Both the code team and the support team were part of the resuscitation process but are "spatially and professionally separated."[77] In the "bifurcated perspective," the physician running the code decides whether or not the family will be allowed in the resuscitation room after the patient has been stabilized or has died. In this particular scenario, the physician behaved in a way that I believe is extremely paternalistic insofar as the decision-making is only done by the physician without the input of the family or others on the code team. At the time of the study, most of the research respondents were categorized within the "bifurcative perspective."

Timmermans' third and final categorization of the opinions of the healthcare professionals in this study were the "holistic perspective."[78] "Healthcare providers who

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[74] Timmermans, 157.

[75] Timmermans, 157.

[76] Timmermans, 157.

[77] Timmermans, 157.

[78] Timmermans, 157.

subscribe to the *holistic perspective* are equally concerned with several outcomes."[79] These outcomes in FPDR included: 1) the survival of the patient 2) maintaining open communication with the family, and 3) allowing the family to be present for the resuscitation.[80] Timmermans reviewed many of the outcomes from the Doyle et al. and the Hanson and Strawser study that support his third category of the "holistic perspective."[81] He maintained that the hospital transition from the "bifurcated perspective" to the "holistic perspective" usually occurred through the personal crusade of a nurse, physician, or chaplain. These persons believed strongly that a more holistic approach must be taken with the family in a resuscitation situation. Timmermans believed that, in order for the resuscitative endeavor to be truly holistic, the general public must be more informed about the limited survival chances of the resuscitative efforts, the need for advanced directives, and have an understanding of futility.[82]

Timmermans' approach, in this quantitative study, provided a very clear summation of the issues surrounding FPDR. He concluded that FPDR programs should continue promoting family presence as an option rather than as a universal policy. He suggested that FPDR should be an option on a case-by-case basis. This belief is more of a departure from the previous studies, although some of the other studies alluded to the possibility that some of the patient situations or some of the families may not be appropriate to attend the resuscitation. Limitations of the study included a small sample

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[79] Timmermans, 157.

[80] Timmermans, 157.

[81] Timmermans, 157.

[82] Timmermans, 167.

size and nonrandom methods of selection. Timmermans admitted that the external validity must be questioned. He believed that the study should be regarded as exploratory and descriptive.[83] More quantitative research will add considerable depth to the FPDR discussion. The use of three categories or concepts made theoretical sense and suggested factors that may facilitate change in the resuscitative perspectives.[84] Clearly, Timmermans' perspectives, sociological background, and unique qualitative study added greater insight into the FPDR research.

In 1998, Meyers, Eichhorn, and Guzzetta did a FPDR quantitative study.[85] All three authors were trained nurses in a large hospital system in Dallas, Texas where the study was performed. The purpose of the retrospective study was to interview families, who had experienced the death of a loved one in the emergency room, but were not given the option of being present during resuscitation. Interview questions were designed to identify what the family's beliefs and feelings would be if they had been given the opportunity to be present during resuscitation. Methodology included a retrospective, descriptive telephone survey of families of patients, who had died in the emergency department following traumatic injuries. Five yes/no questions, with voluntary explanations, were asked of the family member as listed below:

1. If you had been given a chance, would you have wanted to be brought into the room of your loved one just before death while CPR was going on?
2. Do you believe that families should be able to be with their loved ones just before death, if they want to?

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[83] Timmermans, 155.

[84] Timmermans, 166.

[35] Theresa Meyers, Debra Eichhorn, and Cathie Guzzetta, "Do Families Want to be Present During CPR? A Retrospective Survey," *Journal of Emergency Nursing* 24, no. 5 (October 1998): 400-4.

3. If you had been given a chance to go into the room, do you think it might have helped (patient's name)?
4. If you had been given a chance, do you think it would have helped you with your sorrow and sadness after the death of (patient's name)?
5. If you had been given a chance to go into the room, what concerns or questions do you think you might have had? Please explain.[86]

The goal of Meyers, Eichhorn, and Guzzetta was to determine whether or not FPDR was beneficial for the families, if they were given the opportunity to be present during resuscitation.[87] Another purpose of this study was to identify, if there is a relationship between selected demographic data such as patient age, family members ages, education, gender, religion, and relationship to the patient. For example, does the specific relationship to the patient such as a spouse versus a parent or significant other indicate different data outcomes and needs of the family member?[88]

Meyers, Eichhorn, and Guzzetta's study followed nearly fifteen years after the original Foote Hospital survey and their research findings were very similar to those of Doyle et al. Their study was designed to expand and adapt the Doyle et al. study.[89] Meyers, Eichhorn, and Guzzetta began their survey with "twenty-five family members."[90] "Eighty percent" of those family members said they would have wanted to be in the room during resuscitation if they had been given the option.[91] "An

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[86] Meyers, Eichhorn, and Guzzetta, 402.

[87] Meyers, Eichhorn, and Guzzetta, 400.

[88] Meyers, Eichhorn, and Guzzetta, 404.

[89] Meyers, Eichhorn, and Guzzetta, 402.

[90] Meyers, Eichhorn, and Guzzetta, 403.

[91] Meyers, Eichhorn, and Guzzetta, 403.

overwhelming 96% of the families in this study believed that individuals have the right to be present if they so desire."[92] Patient rights were discussed after the respondents answered the question regarding whether or not the family member should be allowed into the resuscitation. (Question two). Consumers are becoming more informed regarding patient's rights. Further study results showed "68% believed their presence would have helped their sorrow following the death (beliefs)."[93] Some of the concerns expressed by the families were related to whether or not the patient would survive the resuscitation or if their presence would interfere with the code team process.[94] Many comments of importance were made in the phone surveys such as; "I wouldn't want my loved one to die with strangers or it would be very important to be with him in his last moments of life."[95] One woman believed that her presence during resuscitation may have eased her loved one's death with the knowledge of her presence. Another family member commented that she would have had less guilt to cope with if she could have been there when he died.[96]

The Meyers, Eichhorn, and Guzzetta study began to look at what families believed would be helpful in their grief. Ultimately, the survey substantiated what has been proven time and time again since the original Doyle et al. study: Families strongly

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[92] Meyers, Eichhorn, and Guzzetta, 404.

[93] Meyers, Eichhorn, and Guzzetta, 400.

[94] Meyers, Eichhorn, and Guzzetta, 404.

[95] Meyers, Eichhorn, and Guzzetta, 403.

[96] Meyers, Eichhorn, and Guzzetta, 403.

support the FPDR option. Consequently, the authors recommended that the code team staff should explore options to implement a FPDR protocol for their hospital.

One of the greatest strengths of the study was the exploration of the family perspective of FPDR. Through retrospective telephone calls, the surveyors were able to elicit candid reactions from grieving family members. Validity of the questions were tested carefully for relevance and clarity from an expert panel of nurses.[97] The focus on grief was very significant as an argument to promote FPDR. Meyers, Eichhorn, and Guzzetta believed their research further justified the need to adopt a family presence program in their Texas hospital.[98]

Late in the 1990s, an innovative study was done by a trauma nurse, Patricia Bassler, in a large, metropolitan hospital in Hartford, Connecticut.[99] The purpose of the research study was to investigate the effect of an educational program about FPDR on nurses' attitudes toward FPDR. Bassler intended to determine if educational intervention among nurses would change their beliefs regarding FPDR.[100] This was a quantitative quasi-experimental pre-test and post-test design. Bassler's study was the first of its kind in the field of FPDR. "Forty–six nurses from both critical care and emergency specialties" volunteered to participate in the research study: 1) by completing a survey, 2) later attending a class about FPDR, followed by 3) another survey to measure the

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[97] Meyers, Eichhorn, and Guzzetta, 400.

[98] Meyers, Eichhorn, and Guzzetta, 405.

[99] Patricia C. Bassler, "The Impact of Education on Nurses' Beliefs Regarding Family Presence in a Resuscitation Room," *Journal for Nurses in Staff Development* 15, no. 3 (May/June 1999): 126-31.

[100] Bassler, 129.

educational intervention influence upon the nurses' beliefs.[101] Class content included information on the obstacles to FPDR such as: the present written laws and hospital policy; views from risk management; timing as to when it might be appropriate to allow the family in the room, support of the families, and determining when and how to allow families into the resuscitation room.[102] Pre-test findings revealed that " [t]wenty-five (55.6%) of the nurses thought the families should be given the choice to be present in the resuscitation room in a sudden death situation."[103] Following the informational class the same group post-tested with "40 (88.9%) thought the family should be given a choice."[104] The second pre-test question asked whether or not the critical care nurse participants had ever given the family a choice of FPDR, "5 (10.9%)" had participated in FPDR.[105] In the post-test results, "43 (79.1%) nurses responded in the affirmative"[106]

Bassler's belief in the importance of FPDR was based upon the theoretical framework of J. W. Worden, the "Conceptual Model for Four Tasks of Mourning."[107] These four tasks include: "1) to accept the reality of the loss, 2) to work through the pain of grief, 3) to adjust to an environment in which the deceased is missing, and 4) to

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[101] Bassler, 129.

[102] Bassler, 129.

[103] Bassler, 130.

[104] Bassler, 130.

[105] Bassler, 130.

[106] Bassler, 130.

[107] J.W. Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner* (New York: Springer Publishing Company,1991): 67.

emotionally relocate the deceased and move on with life."[108] A sudden loss can be surreal and the family member may simply think that it really did not happen. Bassler believed that by having families present in the resuscitation room, nurses can help them move through the first task – accepting the reality of loss.[109] The process of grief was a recurring theme in the studies of the later 1990s as a motivation for a change in the policy toward FPDR.

Bassler's study offered a new approach to the FPRD research literature. She was one of the first to study critical care nurses exclusively and to effectively utilize the intervention of education to persuade more reticent nurses to accept FPDR. One limitation of the study was the inability to discern what formal education levels the nurses had obtained. This may have influenced the ability to persuade the group through educational intervention. The consistency of the delivery of the interventional teaching was not measured and the sample size of the group was only twenty-five. Bassler's study did reveal a positive change in attitudes toward FPDR by the critical care nurses studied.

This last research study of the 1990s rounds out the decade with a very large study that created a great deal of controversy. The 1999 study by Helmer et al. was a large survey of trauma surgeons, the American Association for Surgery of Trauma (AAST) "n = 368 and nurses from the Emergency Nurses Association (ENA), "n = 1261."[110] The purpose of this study was to document attitudes and opinions held by

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[108] Worden, 72.

[109] Bassler, 127.

members of the AAST and a random sampling of the ENA regarding the concept of family presence during trauma resuscitation. Helmer et al. states that FPDR trauma resuscitation is not only controversial but has not achieved widespread acceptance or implementation. He concedes that it is more widely accepted among nurses.[111] Trauma surgeons have reacted to the concept with" considerable skepticism and incredulity."[112]

Beginning the new millennium, significant findings were added to the research database of FPDR. Advanced practice nurses authored many of the new contributions. The purpose of the 2000 study by Meyers et al. was to investigate the attitudes and beliefs of patients, families, and hospital staff members toward FPDR and "Invasive Procedures" (IP).[113] This was the first study to prospectively describe the FPDR experience during both IPs and CPR using the Emergency Nurses Association Guidelines:

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[110]Stephen D. Helmer, Stephen Smith, Jonathan M. Dort, William M Shapiro, and Brian S. Katan, "Family Presence During Trauma Resuscitation: A Survey of AAST and ENA Members," *The Journal of Trauma, Injury, Infection, and Critical Care* 48, no.6 (2000): 1015-24.

[111] Helmer et al., 1015.

[112] Helmer et al., 1015. Common invasive procedures preformed would include: endotracheal intubation central line insertion, lumbar puncture, chest tube insertion, or external pacing.

[113] Meyers, Theresa A., Dezra J. Eichhorn, Cathie E. Guzzetta, Angela P. Clark, Jorie D. Klein, Ellen Taliaferro, and Amy Calvin, "Family Presence During Invasive Procedures and Resuscitation: The Experiences of Family Members, Nurses, and Physicians," *American Journal of Nursing* 100, no. 2 (2000): 32 – 43. Some of the research in FPDR includes the concept of family presence during invasive procedures. Although this research does not include invasive procedures, valuable information can be extracted from these studies specific to FPDR. Many of the issues related to FPDR are similar to FP during invasive procedures, both healthcare professional, family member and patient. IP patients n=24, resuscitation patients n=19. The ENA also includes invasive procedures in their family presence position statement. Studies combining invasive procedures and FPDR are commonly done.

It is the position of ENA that:

1. Emergency department support the option of family presence during invasive procedures and cardiopulmonary resuscitation.
2. Collaboration is needed among specialty organizations (including, but not limited to, nursing, social and family services, pastoral care, physicians, and prehospital care providers) to develop multidisciplinary guidelines related to family presence during invasive procedures and cardiopulmonary resuscitation.
3. Health care facilities should develop and implement formal written policies and procedures that will allow the option of family presence during invasive procedures and cardiopulmonary resuscitation.
4. Health care facilities should involve emergency nurses in the development and implementation of form all written policies and procedures that will allow the option of family presence during invasive procedures and cardiopulmonary resuscitation.
5. Health care organizations should develop and disseminate educational resources for emergency nurses and other ED staff concerning policies, practices, and programs supporting the option of family presence.
6. Health care organizations should develop and disseminate educational resources for the public concerning the option of family presence during invasive procedures and cardiopulmonary resuscitation.
7. Emergency nurses should receive continuing education to increase their understanding of the practice of family presence during invasive procedures and cardiopulmonary resuscitation.
8. Emergency nurses should be actively involved in research related to the presence of family members during invasive procedures and cardiopulmonary resuscitation as well as the short-and-long-term effects of this practice on family members, patients, and health care providers.[114]

A descriptive study was done in the emergency department of a large medical center in Texas by Meyers et al. The purpose of the study was to determine the perceived benefits and problems identified by healthcare team members and family members that were participants in Family Presence (FP) of IP or resuscitation. "We were guided in developing this study by the holistic framework, which directs the caring activities of the health care provider in preserving the wholeness, dignity, and integrity of the family unit

[114] Emergency Nurses Association. Position Statement, "Family Presence At the Bedside During Invasive Procedures and Cardiopulmonary Resuscitation," www.ena.org. retrieved 1/22/10. The ENA also includes invasive procedures in their family presence position statement. This position statement was very important to the acceptance of FPDR.

from birth to death."[115] "Thirty-nine family members" were interviewed regarding their attitudes and experiences while participating as a family member in FPDR or IP.[116] Telephone interviews were done approximately two months after their FP or IP experience. Healthcare professionals participating in the study consisted of "60 registered nurses, 22 physician residents, and 14 attending physicians" who were surveyed seventy-two hours after each FP event.[117]

In the qualitative analysis, family members used phrases such as, "I needed to be there," or they felt it was their right to be with the patient and obligation to the patient, or they needed to provide the patient with support and someone to trust at their side.[118] The family members described the FP experience as "powerful," "natural," "frightening," "difficult," or "scary" but still wanted to be there.[119]

"The views of the health care providers differed significantly: more nurses (96%) and attending physicians (79%) supported FP during resuscitation, than did residents (19%) ($p = 0.001$ for both comparisons)."[120] Families indicated that it was important and helpful for them to be with their loved ones.

> Of the family members nearly all (95%) said that the visitation helped them to comprehend the seriousness of the patient's condition and to know that every possible intervention had been done and to know that every possible intervention had been done.

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[115] Meyers et al., 33.

[116] Meyers et al., 32.

[117] Meyers et al., 32.

[118] Meyers et al., 36.

[119] Meyers et al., 36.

[120] Meyers et al., 33.

> They (95%) also believed that the visit helped the patient---even when the patient was unconscious.[121]

Regardless of the severity of the patient's condition family members commented that they focused on their patient-comforting role rather than on the trauma of the event. Other family members felt "patient-family member connectedness and bonding" during their experience.[122] Families also believed their presence had an effect on the healthcare providers as a reminder of the patient's personhood by comments such as, the family presence "put a soul in the person."[123] Many families felt their presence was an opportunity to say goodbye to their loved ones. "It's like a goodbye that God shares with you," or it offers a "closure on a shared life."[124]

Healthcare professionals had similar reactions and tended to treat the patient with more respect during resuscitation and the code team performed in a more professional manner. In this study and others previously mentioned, Chalk, Timmermans, Mitchell, Redley & Hood found substantial differences in the perceptions of the nurses and residents. The Meyers et al. study suggested the residents' inexperience and discomfort with the technical intervention may have influenced their discomfort with the presence of family.[125] Studies showed that healthcare providers initially opposing FP have a striking shift of opinions when their experiences with FP do not confirm their preconceived

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[121] Meyers et al., 37.

[122] Meyers et al., 37.

[123] Meyers et al., 37.

[124] Meyers et al., 38.

[125] Meyers et al., 39. "… [T]he CPR group, nine of 61(155) providers estimated that they offered more aggressive treatment, extending resuscitation even in futile situations."

concerns and the family benefits become apparent.[126] This study recommended that the practice of FP should address generalizability of the findings, focus on outcomes with different populations in different settings, and include longer-term family follow-up.[127] Future studies may chose to take a closer look at the length of the resuscitation efforts to determine whether FP alters the activities length, activity, or cost.[128] Results of the study revealed that even in the crisis of death the staff was able to fulfill the holistic imperative of preserving the wholeness and integrity of the family. Researchers suggested that routinely banning families from the bedside during IPs and CPR should be discontinued. FPDR does not disrupt operations of the code team.[129] Also, FPDR does not produce adverse psychological effects on participating family members.[130] Nearly all of the families would choose to be present again.[131] As with many of the previous regional studies, one of the underlying purposes of the study was to convince the healthcare personnel to adopt FP policies and practices in their particular hospital. The Meyers et al. study was able to positively affect such a change in their hospital policy and adopt new understanding and acceptance of a FPDR and IP policy favoring family presence.[132]

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[126] Timmermans, Mitchell, and Belanger.

[127] Meyers et al., 40.

[128] Meyers et al., 40.

[129] Meyers, Doyle, Hansen, Robinson, Belanger.

[130] Meyers, Belanger.

[131] Meyers, Doyle, Belanger.

[132] Meyers et al., 40.

Following the Meyers study of 2000, Dezra Eichhorn, one of the authors in the Meyers study, along with many of the same colleagues studied the perceptions of the patients who had family in attendance during IP or FPDR.[133] This was the first time in all of the FPDR and IP studies that the patient was the center of the study. Eichhorn, using a semi-structured questionnaire interviewed nine patients, eight who had IPs and only one patient that was resuscitated. Careful analysis by five other researchers trained in qualitative methods of research assisted in the interpretation of the findings. All of the investigators agreed that the analysis accurately reflected the content of the written transcript. Seven themes emerged from the data:

1. Being comforted
2. Receiving help
3. Reminder of personhood
4. Maintaining patient-family connectedness
5. Discerning family presence as a right
6. Perceiving how family presence affected family members
7. Perceiving how family presence could affect the health care environment[134]

These findings were very similar to the findings in the Meyers et al. study which demonstrated that family members also believed family presence was a right that provided comfort, help, and connectedness and served as a reminder of personhood.[135] All of the nine patients interviewed found family visitation beneficial. This study was small but able to capture the "patient's voice" which often times is forgotten or ignored. The authors were fully aware of the limitations of the size of the study and the

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[133] Dezra J. Eichhorn, Theresa A. Meyers, Cathie Guzzetta, Angela Clark, Jorie D. Klein, Ellen Taliaferro, and Amy O. Calvin, "Family Presence During Invasive Procedures and Resuscitation: Hearing the Voice of the Patient," *American Journal of Nursing*" 101, no. 5 (May 2001): 48-55.

[134] Eichhorn et al., 51.

[135] Eichhorn et al., 53.

homogenous demographics. Evidenced based practice such as the common findings in the studies of FPDR and IP are replacing the unsupported data of the emotional arguments of the past. The growing numbers of FPDR studies are offering "cumulative, consistent positive findings, generated from a growing number of family presence studies."[136]

Contrasting the results of several of the previous surveys, was a large study done in 2002 by McClenathan, Torrington, and Uyehara.[137] In the August 22, the 2000 issue of *Circulation* by the American Heart Association, the 2000 Guidelines for Emergency Cardiovascular Care (ECC) and cardiopulmonary resuscitation (CPR) were published. Guidelines advocated family witnessed resuscitation and recommend that family members are allowed to be with the patient during CPR; this spurred considerable controversy.[138] The major objective of the study by McClenathan, Torrington, and Uyehara was to survey a large group for their opinions regarding FPDR at an international meeting of the American College of Chest Physicians in the Fall of 2000.[139] "Five hundred ninety-two professionals were surveyed."[140] The majority of the surveys were from physicians who were associated with multiple clinical specialties. Surprisingly, " . . . the majority (78%) of all of the health-care professionals surveyed

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[136] Eichhorn et al., 55.

[137] Bruce M. McClenathan, Kenneth G. Torrington, and Catherine F.T. Uyehara, "Family Member Presence During Cardiopulmonary Resuscitation: A Survey of US and International Critical Care Professionals," *CHEST* 122, no. 6 (December 2002): 2204-07.

[138] American Heart Association. "Guidelines 2000 for Cardiopulmonary Resuscitation: part 2: Ethical Aspects of CPR and ECC," *Circulation* 2000; 102(suppl): 112-121.

[139] McClenathan, Torrington, and Uyehara, 2204.

[140] McClenathan, Torrington, and Uyehara, 2204.

opposed FWR for adults."[141] There were significant differences in opinions regarding FPDR based upon regional locations of the healthcare professional. Professionals practicing in the northeast United States were less likely to allow FPDR compared to healthcare professionals in the rest of the US. Midwest healthcare professionals were more likely to allow FPDR of the adult patient than those in the rest of the country.[142] Respondents, who disapproved of family member presence during resuscitation, listed several reasons; the most frequent was a concern for the psychological trauma to witnessing family members. Other reasons cited were medico-legal concerns, performance anxiety affecting CPR, and fear of the family distracting the resuscitation team.[143]

Similar findings, of this study, represented the findings in the large group of physicians studied by Helmer of the American Academy of Surgeons and Trauma.[144] Almost seventy-five percent of those physicians who had experience with FPDR had a negative response, similar to the "sixty percent" negative response of experienced FPDR physicians in the McClenathan, Torrington, and Uyehara study.[145]

This study confirmed the findings that nurses "are statistically more likely to support FWR than physician colleagues ($p = 0.02$)."[146] The authors believed that the

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[141] McClenathan, Torrington, and Uyehara, 2206.

[142] McClenathan, Torrington, and Uyehara, 2207.

[143] McClenathan, Torrington, and Uyehara, 2207.

[144] Helmer et al., 1015.

[145] McClenathan, Torrington, and Uyehara, 2206.

[146] McClenathan, Torrington, and Uyehara, 2209.

nursing attitude in comparison to the physician's attitude toward FPDR was a result of the nurses decreased legal liability or that nurses generally receive greater emphasis in their education on patient-family centered dynamics than medical students.[147]Also speculated, the physician's ultimate responsibility for the outcomes of the resuscitative efforts poses greater pressure on his/her decision making in regards to FPDR. Contrary to many of the previous studies on FPDR, the McClenathan, Torrington, and Uyehara study showed a significant difference of opinion on FPDR based upon previous experience. Healthcare professionals lacking in previous FPDR experience were more likely to recommend FPDR than those professionals that had previous experience. The authors claim that the contrary outcomes in this area come from "professionals who have participated in typically hectic CPR attempts with difficult vascular access and tracheal intubation, emesis, and rib fractures, understand the reality of CPR and have concluded that family members should be excluded from witnessing these events."[148] Other studies, with divergent outcomes had substantiated their results based upon the young physician or resident's lack of experience and discomfort with the procedures.[149] This discomfort was more problematic when witnessed by the family, not necessarily an ethical issue witnessed by the doctors.

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[147] McClenathan, Torrington, and Uyehara, 2209.

[148] McClenathan, Torrington, and Uyehara, 2210.

[149] Potential that provider's technical skill would be affected because providers were uncomfortable with family member's presence; (Eichhorn 1996, Hanson/Strawser, Doyle et al., Timmermans, Berlinger, Redley/Hood, Helmer, Chalk).

While the McClenathan, Torrington, and Uyehara study discussed the limitations of their work, such as sample biasing and no reported validity of reliability, they believed the results of this large group of healthcare professionals, primarily physicians, should not be taken lightly. Conference participants, in the survey, did not support current recommendations declared by the ECC and CPR guidelines of 2000. "Our survey participants, critical care professionals who frequently deal with end-of-life issues, are on the front lines of medical ethics, and their strongly negative attitude toward FWR cannot be dismissed as uninformed."[150] McClenathan, Torrington, and Uyehara concluded their study with a strong recommendation that the American Heart Association must continue to implement "rigorous scientific study" of FPDR before they implement their 2000 recommendations into practice.[151]

By 2003, three more studies in FPDR were published beginning with a study by Susan MacLean et al. composed of a varied group of some of the same authors in the Meyers et al. and Eichhorn et al. FPDR research studies.[152] The objective of MacLean's work was to identify policies, preferences, and practices of critical care and emergency nurses for having patients' families present during resuscitation and invasive procedures. This was the first study to examine only critical care nurses and emergency room nurses

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[150] McClenathan, Torrington, and Uyehara, 2210. Family Witnessed Participation (FWP) is another term used interchangeably with FPDR.

[151] McClenathan, Torrington, and Uyehara, 2210.

[152] Susan L. MacLean, Cathie E. Guzzetta, Cheri White, Dorrie Fontaine, Dezra Eichhorn, Theresa A. Meyers, and Pierre Desy, "Family Presence During Cardiopulmonary Resuscitation and Invasive Procedures: Practices of Critical Care and Emergency Nurses," *America Journal of Critical Care 12, no. 3* (May 2003): 246-57.

in the United States in the context of FPDR and IP.[153] A "thirty-item survey" was mailed to a "random sample of 1500 members of the American Association of Critical-Care Nurses and 1500 members of Emergency Nurses Association."[154] The response rate of "thirty-three percent rendered 984 respondents for the study."[155] Perhaps one of the most interesting outcomes was that " . . . only five percent of the respondents worked on units that had written policies allowing the option of family presence during CPR (51/969) or invasive procedures (48/961)."[156] Written policies prohibiting family presence in either instance were rare. Although most of the units did not have formal written policies for FPDR and IP, almost half of the respondents reported that their units allowed the option of family presence. MacLean et al. maintained that this informal result of changes in the practice of allowing family presence reflected an increasing focus on family-centered care. The authors also believed that there is a growing desire to meet holistic needs of patients and their family members as well as an increasing attention paid to family presence, in the professional and public literature, which may increase the assertiveness of the patients' families.[157]

Most of the respondents, in the study, had taken or will consider taking the family to the bedside during CPR and invasive procedures. "Thus, nearly 75% of the

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[153] MacLean et al., 252.

[154] MacLean et al., 247.

[155] MacLean et al., 247.

[156] MacLean et al., 249.

[157] MacLean et al., 253.

respondents favored some type of option for allowing family presence."[158] This figure was consistent, although slightly lower than the percentage noted in the Meyers et al. study, reporting ninety-six percent emergency nurses supported family presence during CPR.[159]

MacLean et al. identified the limitations of the study as deficient in" reliability testing, no established construct validity," and a low return rate of "thirty-three percent" affecting the "limited generalizability of the findings," which is primarily limited only to this group of nurses.[160]

Recommendations for practice from this study were very valuable. Nearly all of the respondents, to the survey, worked on units that had no written policy on family presence, yet "seventy-five percent" of the respondents preferred that family presence be allowed. Benefits to family presence have been well established in many previous studies and confirmed in this study.[161] Critical care nurses and emergency room nurses should consider developing written policies or guidelines on family presence to meet the needs of the patients, their families, and provide consistent, safe, and caring practices for patients, patients' families, and the staff.[162]

Several months later, in 2003, the *Journal of Emergency Nursing* published a smaller study of hospital nurses and Emergency Nurse Association (ENA) member's

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[158] MacLean et al., 253.

[159] Meyers et. al., 36.

[160] MacLean et al., 254.

[161] MacLean et al., 253.

[162] MacLean et al., 255.

attitudes and beliefs about family presence during resuscitation or invasive procedures in New Jersey by a single researcher, Susan Ellison.[163] "Two hundred and eight registered nurses (RNs) and licensed practical nurses (LPNs) completed the survey for a response rate of 42%. The sample consisted of 99% RNs (n = 193 and 1% LPNs (n = 15)."[164] The respondents were asked to complete a "thirteen-item Family Presence Support Staff Assessment Survey," which included a qualitative component. This particular survey was designed to identify healthcare practitioners' attitudes to FPDR and IP.[165] It was also designed to identify the relationship between demographic variables and nurses' attitudes and beliefs including: educational preparation, specialty certification, experience, and completion of a family presence educational offering, age, sex, and ethnicity.[166]

Subjects of the study were predominantly white women between the ages of forty-one and fifty-five years old.[167] This particular demographic was quite narrow. Demographic results revealed that education, specialty certification, professional designation, and the specialty area where nurses work are all statistically significant predictors of attitudes toward family presence. Nurses are more likely to be in favor of allowing family presence during invasive procedures than resuscitation and also more likely to be present at their own family members resuscitation than to allow the general

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[163] Susan Ellison, "Nurses' Attitudes Toward Family Presence During Resuscitative Efforts and Invasive Procedures," *Journal of Emergency Nursing* 29, no. 6 (December 2003): 515-21.

[164] Ellison, 516.

[165] Ellison, 516.

[166] Ellison, 516.

[167] Ellison, 517.

public the same opportunity. The qualitative data analyzed and identified the following recurring themes opposing other family presence because of the interference of their job performance:

1. Environmental limitations,
2. Demand on subjects' time,
3. Lack of personnel who can address emergent issues and needs of family members,
4. Untoward responses by family members,
5. Lack of education and capacity of family members to understand the event.[168]

Significant relationships were found between positive attitudes toward family presence and higher education and emergency nurse specialization. Ellison points out that these findings concurred with the Helmer et al. study in 2000. Implications of this study indicated that "[e]ducation that raises the consciousness of the staff and addresses concerns is a necessity for changing the mind-set and attitudes of staff."[169]

Perhaps the most striking result, in this study, was the double standard held by many of the staff members in the belief that their presence with their own family will be beneficial but not so with the general public.[170] "Eighty-seven percent" of the nurses indicated they would want family presence, if they were ill or injured.[171] The nurses identified their personal barriers for family members presence as an "1) inability to manage issues relevant to death and dying, 2) discomfort with family members observing their performance at these situations, and 3) their own fear of litigation. They also identified old belief systems that are hard to break down ('that's the way is has always

[168] Ellison, 518.

[169] Ellison, 520.

[170] Ellison, 518.

[171] Ellison, 518.

been done')."[172] All of these barriers have been identified time and time again in other research. Ellison reports that further education of the staff is recommended.[173]

The study sample was drawn from one hospital and one professional nursing organization, limiting the generalizability of the data.[174] Ellison believed that comparative studies validating the outcomes of the specific educational programs on family presence needed to be conducted across a multidisciplinary group of practitioners in a varied number of healthcare organizations to be a more effective study.[175] Ellison added a poignant quote from a nurse who was denied access to a loved one during resuscitation. This quote succinctly describes the importance of family presence:

> I don't know your name, but I will never forget you. You played a part in the most important event in my life. But you didn't share that painful experience with me; you just happened to be present. I want to leave you with this thought. Death is painful for all families. When it's expected, family members usually have time to say goodbye. But when death is unexpected, there's no time for those last intimate moments. I had one opportunity – one moment in time to sit by a stretcher, hold a warm hand, and say goodbye. You stole my moment.
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> BR Phillips. "Letter from the Heart." *RN* 2002; 65:36-9.[176]

The third and final study done in 2003 was performed by two physicians, Marco and Larkin. They took a unique approach to determine the effect of a multimedia educational intervention on knowledge base and resuscitation preference among the lay public. Marco and Larkin attempted to measure the effects of a novel multimedia

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[172] Ellison, 520.

[173] Ellison, 520.

[174] Ellison, 520.

[175] Ellison, 520.

[176] BR Phillips. "Letter from the Heart." *RN* 2002; 65:36-9 in Ellison, 520.

intervention on knowledge and preferences.[177] A self-administered survey was developed to determine knowledge, opinions, and personal preferences regarding CPR among the lay public as a pre-intervention tool. Following the initial survey the participants were provided an eight-minute educational video to portray factual information regarding resuscitation. Participants were resurveyed to determine the influence of factual information given to them as lay public.[178]

Marco and Larkin began their study with " . . . 310 participants selected from; community events (n=155), university classrooms (n=126), and physician waiting rooms (n=12)."[179] "Pre-intervention results indicate markedly inaccurate perceptions of cardiac arrest outcomes."[180] The median estimate of survival by the pre-interventional group was "fifty percent," followed by a post-interventional estimate of "sixteen percent."[181] Similarly, the median estimate of duration of resuscitation was estimated at "thirty minutes" on the pre-survey and a more accurate "nineteen minutes" on the post-intervention al survey.[182]

"Both the pre-intervention and post-interventional testing demonstrated a relationship between personal preferences in a series of hypothetical resuscitation

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[177] Catherine A. Marco and Gregory L. Larkin, "Public Education Regarding Resuscitation: Effects of a Multimedia Intervention," *Annals of Emergency Medicine* 42, no. 2 (August 2003): 256-60.

[178] Marco and Larkin, 257.

[179] Marco and Larkin, 257.

[180] Marco and Larkin, 258.

[181] Marco and Larkin, 257.

[182] Marco and Larkin, 258.

scenarios and expected outcomes."[183] At the pre-interventional survey, " . . . 97% would desire resuscitation in the scenario depicting a healthy twenty-five year old patient, but only 34% would desire resuscitation in the scenario depicting a 75-year-old patient who is terminally ill. All of the participants indicated that there should be no age limit beyond which resuscitative efforts should be routinely withheld (n=310)."[184] This opinion was unchanged after the educational video.[185]

Marco and Larkin found significant changes in the participant's preferences with resuscitation in the hypothetical scenarios following the multimedia intervention. Overall, the participants were less willing to undergo resuscitation in all hypothetical scenarios after the video.[186] Participants identified factors that they believe physicians should consider when making resuscitation decisions by way of a five-point Likert scale. The most important consideration was the patient's wishes, followed by the patient's current health, then the physician's opinion, family wishes, and lastly, the patient's age.[187] Occupation and citizenship were consistently seen as "unimportant factors to consider in resuscitative decisions."[188]

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[183] Marco and Larkin, 258.

[184] Marco and Larkin, 258.

[185] Marco and Larkin, 258.

[186] Marco and Larkin, 258.

[187] Marco and Larkin, 258.

[188] Marco and Larkin, 258.

Findings of this study reported the publics' "unrealistically high expectations of survival rate after cardiac arrest."[189] Marco and Larkin suggested that the optimism of the public may be based upon the inaccurate portrayal of resuscitation success through media. This study clearly demonstrated that resuscitation preferences of the public are linked closely to "knowledge and perception regarding CPR."[190] An improved knowledge base regarding resuscitation may be achieved by more realistic portrayals in the media, online education, and more education in the physicians' office.[191] This study demonstrated short-term effectiveness improves the accuracy of knowledge regarding CPR, but recommends the need for further study in measuring the effects of long-term retention of the information.[192] Further studies were suggested regarding the effects of the actions of the participants in advance directives, communication with family, friends, and medical personnel. Marco and Larkin also emphasized that improved public education regarding resuscitation was warranted.[193]

To date there have not been any studies that have examined whether or not the patient wants the family present during their own resuscitation. Benjamin, Holger, and Carr, all physicians, created a method to study what patients believe are needed at the time of resuscitation.[194] These emergency room physicians distributed a survey of a

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[189] Marco and Larkin, 258.

[190] Marco and Larkin, 258.

[191] Marco and Larkin, 258.

[192] Marco and Larkin, 259.

[193] Marco and Larkin, 259.

[194] Marny Benjamin, Joel Holger, and Mary Carr, "Personal Preferences Regarding Family Member Presence during Resuscitation," *Academic Emergency Medicine* 11, no.7 (July 2004): 750 -53.

convenience sample to patients waiting in the waiting room of the emergency room during six randomly chosen eight-hour shifts. The following scenario was constructed for participants in the study to read prior to answering a single question:

> Some family members find it emotionally helpful to be present at the resuscitation of a critically ill or injured loved one. This means the family members are in the same room with the nurses and doctors as they provide medical care. The patients are often naked. Some bodily fluids (i.e., blood, urine, stool) may be present. Medical care being given may include CPR: somebody is pushing on the patient's chest in order to keeps the blood flowing in the patient's body. IV lines may be put into veins, minor surgical procedures may b done, like making cuts with a knife to put in chest tubes, catheters may be placed to get urine from the bladder, and a tube may also be placed in the patient's throat to allow breathing. The patient may also require defibrillation: delivering electricity through paddles or patches placed on the patient's chest to try to restore a normal heart rhythm. At the time this is occurring, a nurse may ask the family members if they would like to be present in the room. The nurse would stay with the family to help them understand what is happening.[195]

The primary question asked of participants was, "If you were seriously injured or sick requiring some or all of the above procedures, would you want to have your family members present while the doctors and nurses were providing care for you?"[196] Possible responses included the following: 1) Yes; 2) I would want only certain relatives allowed in the room, 3) No: and 4) I would not want to be resuscitated at all.[197]

A total of "266 subjects" were approached to participate in the survey and "200 completed surveys."[198] "Of the 200 respondents, most (72%) responded favorably to having family present during resuscitation. . . ."[199] The researchers concluded that

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[195] Benjamin, Holger, and Carr, 751.

[196] Benjamin, Holger, and Carr, 751.

[197] Benjamin, Holger, and Carr, 751.

[198] Benjamin, Holger, and Carr, 751.

[199] Benjamin, Holger, and Carr, 751.

patients preferred to have family members present during resuscitation, however, most of the positive responders wanted "only certain family members present."[200] Benjamin, Holger, and Carr concluded that most patients and their accompanying family member favored FPDR in their own potential resuscitation.[201]

Limitations of the study were discussed and recommendations for further study are stated. Perhaps the most compelling argument, in the limitations, is that the scenario may not have been understood by some of the respondents and also the graphic nature of the scenario may have elicited too much of an emotional response.[202] These physicians did not intend to introduce a new policy in their hospital as many in the past have done. Their goal was to determine the patients' preferences regarding family member presence during their own resuscitation.[203] Researchers admitted the nursing staff was more likely to allow family presence than the medical staff. Finally, the researchers did not support an open policy of FPDR without prior knowledge of the patient's preference.[204] One has to consider how realistic it is to have prior knowledge of the patient's FPDR preferences when there is already so much difficulty in retrieving the advance directive for the patient.

A similar study done in the same year, 2004, took public opinion one-step further. Berger, Brody, Epstein, and Pollack posed the research question, "Should patient and

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[200] Benjamin, Holger, and Carr, 751.

[201] Benjamin, Holger, and Carr, 753.

[202] Benjamin, Holger, and Carr, 753.

[203] Benjamin, Holger, and Carr, 750.

[204] Benjamin, Holger, and Carr, 752.

family interest alone determine whether third parties should attend CPR?"[205] This study was done in an emergency room setting through the distribution of a self-administered survey tool. The tool included a description of CPR, which was less graphic than the Benjamin, Holger, and Carr study. Subjects were asked about their preferences for attending a relative's CPR, for having a relative attend their CPR, and for having a relative attend their CPR, if the relative expressed a desire to attend.[206] Each of the questions were asked in relation to a spouse, parent, sibling, adult child, minor child, and a significant other. "Thirty-one persons returned completed surveys for an overall inclusion rate of 72 percent."[207] For the question of whether subjects wanted to be present at a relative's CPR, participants indicated a "modest preference to attend" CPR.[208] The question regarding a relative attending their own CPR; subjects expressed a "moderate preference for a spouse to be present."[209] Pertaining to the same questions involving a minor child, the response was "probably not present."[210] The questions regarding whether a relative who "hypothetically" expressed a preference to attend a

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[205] Jeffrey T. Berger, Gerald Brody, Lawrence Epstein, and Simcha Pollack, "Do Potential Recipients of Cardiopulmonary Resuscitation Want Their Family Members to Attend? A Survey of Public Preferences," *The Journal of Clinical Ethics* 15, no. 3 (Fall 2004): 237–42.

[206] Berger et al., 238.

[207] Berger et al., 238.

[208] Berger et al., 238.

[209] Berger et al., 238.

[210] Berger et al., 238.

family member's CPR "should be allowed to do so."[211] Respondents tended to accommodate relative's wishes.[212]

Admittedly, the study was very small and should pursue a larger participant number. Berger et al. concluded from their study, "although potential patients may express an interest in attending their relative's resuscitation, they are less interested in having a family member attend their own CPR, unless the family member expresses a desire to do so. Additional studies would be useful in understanding reasons underlying patients' and families' preferences on these issues."[213]

An increasing number of the research surveys have been prompted surrounding the need for hospital personnel to be exposed to FPDR, educated, and to implement a new policy to support FPDR. Another such research study by Mangurten et al., in 2005, was established to expose the hospital to FPDR and IP, write a policy, and introduce a change in their practice.[214] Mangurten et al. developed a survey entitled, "Self-Assessment Survey Related to Family Presence During Invasive Procedures and Resuscitation Interventions."[215] "Of the 290 distributed surveys, 109 were completed and returned (a 38% response rate) . . . most were physicians (38%) and nurses (36%)."[216] Survey results reflected similar findings to past studies such as the perceived benefits of

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[211] Berger et al., 238.

[212] Berger et al., 238.

[213] Berger et al., 242.

[214] Janice Mangurten, Shari Scott, Cathie Guzzetta, Jenny Sperry, Lori Vinson, Barry Hicks, and Douglas Watts, "Family Presence: How One Hospital Implemented a Family Presence Policy for Invasive Procedures and Resuscitation Interventions, *American Journal of Nursing* 105, no. 5 (May 2005): 40-8.

[215] Mangurten et al., 42.

[216] Mangurten et al., 42.

FPDR and IP, to facilitate the grieving process and provide closure if death should occur. Some staff members viewed family presence as an integral part of healthcare and believed that family members should always have the option of attending.[217] Others viewed FP as an impediment expressed through "anxiety and performance in the presence of family."[218] Some participants felt a policy would impose FP on both the staff and the family whereby the family would feel it is an expectation to be present. This research article included the questions of the survey, which were very helpful for the reader and may assist future hospitals in a similar survey process. Mangurten et al. included a hospital policy that presented various guidelines to implement FPDR and IP into the hospital setting. Following the implementation of the new FPDR and IP was a three-month evaluation period to measure the progress of the policy. The evaluation form measured three items:

- a family member was an appropriate candidate for family presence.
- the family facilitator had to escort family members out of the room because they were overwhelmed or disruptive.
- patient care was interrupted.[219]

Results of the evaluation revealed that the policy was "implemented correctly, that it was effective in screening candidates for bedside presence, and that it did not disrupt patient are."[220]

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[217] Mangurten et al., 44.

[218] Mangurten et al., 44.

[219] Mangurten et al., 47. A facilitator is a designated person who prepares family for FPDR and attends the room with the family member. The person could be a nurse, social worker, pastor or other.

[220] Mangurten et al., 47.

Mangurten et al. recommended that long-term effects of the family members be studied to determine any possible negative affects for attendance. In this closing statement of the study, Mangurten et al, states " . . . until new data emerges to demonstrate that the problems outweigh the benefits, there is no reason not to formalize the practice and establish family presence programs as an option for all families."[221]

The next two studies approached the general public and sought their opinions or perceptions on FPDR. The first, by Mazur, Cox, and Capon (2006) was a study designed to develop insight concerning the public's thoughts about witnessed CPR.[222] This qualitative study was performed in rural Pennsylvania using a random telephone survey. Respondents were given five statements concerning witnessed resuscitation and then asked to rate their level of agreement to each statement using a five point Likert scale.

1. I believe family members or friends have the right to be present in the room while a loved one is undergoing CPR.
2. I would want to be in the room with a loved one during CPR.
3. I would want family members or friends with me if I were undergoing CPR.
4. The presence of family members or friends during CPR would benefit the patient.
5. The presence of family members or friends during CPR would benefit the family members of friends.[223]

A telephone survey was designed as the second portion of the study requesting the respondents to rank in order of preference whether the patient, physician, or family and friends should have the most authority in the decision to allow witnessed resuscitation.

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[221] Mangurten et al., 47.

[222] Mark. A Mazur, Lori A. Cox, and J. Anthony Capon, "The Public's Attitude and Perception Concerning Witnessed Cardiopulmonary Resuscitation, *Critical Care Medicine* 34, no. 12 (December 2006): 2925–28.

[223] Mazur et al., 2926.

The last section of the survey was to elicit respondents' general thoughts and comments about witnessed resuscitation.

"A total of 408 telephone interviews were completed. . . ."[224] The highest level of agreement was identified in the respondents desire to be present while CPR is performed on a loved one, "49.3%" stated that they "strongly agree" or "agree" with the statement.[225] Respondents agreed with the premise that family and friends would benefit from being present during CPR. "Overall, 43% of the respondents believed that physicians should have the most authority, closely followed by patients (40%), whereas only 17% of respondents believed that family and friends should have the most authority."[226]

Mazur et al. concluded that people who desire CPR are generally more likely to have positive feelings about witnessed resuscitation.[227] Limitations of this study were in the telephone survey interpretation and that the generalizability was limited in the sample obtained in southwest Pennsylvania. Further studies in more diverse populations and urban regions are warranted. An attempt to seek public opinion was a worthy study to add new data and perspective to the discussion of FPDR.

The next public survey was done in 2008, performed by Marco and Larkin to identify the accuracy and knowledge, and establish opinions of the general public

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[224] Mazur et al., 2926.

[225] Mazur et al., 2927.

[226] Mazur et al., 2927.

[227] Mazur et al., 2926.

regarding cardiopulmonary resuscitation.[228] Remember previously, in 2003, Marco and Larkin did research, with the general public, using video media to educate the public. This large self-administered survey with "1831 participants" was conducted in community settings in Pennsylvania and Ohio.[229] Locations included airport terminals, bus terminals, hospital waiting rooms, shopping malls, and college campuses. Marco and Larkin believed that "although numerous authors have suggested certain approaches to resuscitative decision-making, the opinions of the general public regarding resuscitation, financial investments in resuscitative efforts, and personal opinions are largely unknown."[230] They planned to identify the accuracy of knowledge, and establish opinions of the general public regarding cardiopulmonary resuscitation. The study had several sections to be completed; demographics, hypothetical clinical scenarios, personal resuscitation preferences, advance directives, acceptable procedures, financial issues, and general knowledge about resuscitation. The survey was rather complicated yet comprehensive in its scope to identify the issues of the general public. Appropriate steps were taken to validate the internal reliability of the survey instrument before embarking upon the actual distribution. Findings in each area of the study identified varying opinions and limited factual knowledge. Section one, regarding knowledge about cardiopulmonary resuscitation, showed a very inaccurate perception of the survival rate in cardiac arrest. "Participants' mean estimate of predicated survival rate after cardiac

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[228] Catherine A. Marco and Gregory L Larkin, "Cardiopulmonary Resuscitation: Knowledge and Opinions Among the U.S. General Public State of the Science-Fiction", *Resuscitation* 79 (July 2008): 490-98.

[229] Marco and Larkin, 2008, 491.

[230] Marco and Larkin, 2008, 491.

arrest was 54% (median 50%, IQR 35-75%), and mean estimated duration of resuscitative efforts in the ED was 28 minutes (median 15 min; IQR 10-30)."[231]

Participants rated several factors for importance in the event of their own cardiac arrest. Below, these items were ranked in order of importance by the participants:

Most advanced technology	90%
Physician communication with family	85%
Family presence in the hospital	72%
Prayer/other religious acts	57%
Clergy communication with family	53%
Family presence in resuscitation room	31%[232]

Participants were also asked what they felt should be considered by physicians in terms of making resuscitation decisions. The top four answers, in order of preference, were; patient wishes, family wishes, patient's health status, and physician opinion or prediction of outcome.[233] Participants indicated their own preferences in the event of a cardiac arrest for a series of hypothetical scenarios. These four scenarios posed a series of hypothetical individuals with different ages, levels of wellness," terminal illness," and "sudden cardiac death."[234] "Although both age and health status were independent predictors of resuscitation preferences hypothetical scenarios, health status had a greater impact on preferences."[235]

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[231] Marco and Larkin, 2008, 491. IQR is the interquartile range, which is used in statistical analyses to help draw conclusions.

[232] Marco and Larkin, 2008, 492.

[233] Marco and Larkin, 2008, 492.

[234] Marco and Larkin, 2008, 492.

[235] Marco and Larkin, 2008, 490.

Another portion of the study dealt with questions pertaining to advance directives. "Although the majority of respondents had a personal physician (N=1476), 80.6%) only 10.9% (N=200) of respondents had ever discussed death or resuscitation with their physicians."[236] The final category was the financial issues associated with CPR. "Many respondents indicated that the high costs paid by society are appropriate for attempted cardiac resuscitation (not necessarily successful)."[237] However, Marco and Larkin believed these opinions may be supported by the unrealistic expectations of survival of the resuscitation.

Marco and Larkin's study had limitations common to all self-administered survey data, such as whether or not the responses actually represent a general public opinion or those that chose to take the study may be more opinionated than those that refused the study.[238] The authors concluded that inaccurate perceptions regarding resuscitation and survival rates exist among the general lay public. Many people have strong personal opinions regarding resuscitation, personal preferences, and financial issues regarding resuscitation. Improved public education regarding resuscitation and heightened efforts to improve communication regarding resuscitation preferences are recommended by Marco and Larkin.[239]

Adding to the growing body of FPDR research was another study done in 2007 by Duran et al. using the same survey tool introduced by Meyers et al., 2000 at Parkland

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[236] Marco and Larkin, 2008, 492.

[237] Marco and Larkin, 2008, 493.

[238] Marco and Larkin, 2008, 494.

[239] Marco and Larkin, 2008, 494.

Health and Hospital System in Texas.[240] The purpose of the study was "to describe and compare the beliefs about and attitude toward family presence of clinicians, patients' families, and patients."[241] The primary difference in this study from the Meyers et al. 2000 research was this study gathered the participants' attitudes toward and beliefs about family presence regardless of whether participants had previous experiences with family presence. The Duran et al. study was done at the University of Colorado Hospital in several critical care areas. "Surveys were completed by 202 clinicians, 72 family members and 62 patients."[242]A reasonable sample size was obtained from clinicians, " . . . for an 18% overall response rate (1095 surveys mailed)."[243] "Of the 202 healthcare providers who returned a survey, 98 were nurses, 98 were physicians, and 6 were respiratory therapists."[244] Healthcare professionals had an overall positive attitude about family presence.[245] Respiratory therapists had higher scores than the physicians and nurses in this study. The attitude of healthcare professionals who were involved in a family witnessed resuscitation differed from those who were not.[246] Attitudes differed significantly between nurses and physicians and between non-attending physicians

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[240] Christine R. Duran, Kathleen S. Oman, Jenni Jordan Abel, Virginia M. Koziel, and Deborah Szymanski, "Attitudes Toward and Beliefs About Family Presence: A Survey of Healthcare Providers, Patients' Families, and Patients, *American Journal of Critical Care* 16, no. 3 (May 2007): 270-79.

[241] Duran et al., 270.

[242] Duran et al., 270.

[243] Duran et al., 273.

[244] Duran et al., 275.

[245] Duran et al., 275.

[246] Duran et al., 275.

(interns, residents, and fellows) and attending physicians.[247] Typical of many of the previous studies, nurses had more positive attitudes toward family presence than did physicians.[248] A total of "72 family members" and "62 patients" responded to the survey.[249] "Patients and their families had positive attitudes toward family presence."[250]

A portion of the survey was a qualitative design and participants were encouraged to elaborate their feelings and thoughts. Several themes emerged from the healthcare professionals qualitative data involving safety of patients and family. "Frequent comments included worries about family members 'fainting,' 'getting in the way,' and causing 'disruption' – actions that could lead to poor outcomes for a patient if attention were diverted away from care of the patient to the family member."[251] Another emerging theme was the concern about emotional responses or outbreaks of the patients' family members.[252] Healthcare professionals also worried about "traumatizing" the family during FPDR.[253] Additionally the clinicians expressed many feelings of performance anxiety, not unlike most of the previous studies done in FPDR.

Family members felt it was their right to be present in the resuscitation. Other findings were similar to most of the other studies done such as; the family wanted the

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[247] Duran et al., 275.

[248] Bassler, Chalk, Helmer, McClenathan, Meyers, 2000, Timmermans.

[249] Duran et al., 270.

[250] Duran et al., 270.

[251] Duran et al., 276.

[252] Duran et al., 277.

[253] Duran et al., 277.

option to be present during CPR, wanted to see what was being done for their loved one, would be better able to understand the severity of the situation by witnessing CPR and felt their presence would be helpful to their loved one and to themselves.[254]

Patient comments were similar to the above family member comments. They too, felt it was their right to have a family member present and that the option of family presence should be extended to them. They also felt that family presence would be a comfort to them in a resuscitation situation.[255]

Duran et al. discussed their findings as they pertain to previous FPDR research. In their study, the non-attending physicians had a more favorable attitude toward family presence than the attending physicians.[256] This was an unusual finding. Researchers concluded that family presence is an acceptable practice. Family presence will benefit both the patient and the patient's family.[257] The Duran et al. study was primarily a repeated study of the Meyers et al. 2000 study with limited differences in their outcomes.

During the same year as the previous study, 2007 was an "inform and implement" study done in a hospital to introduce a family presence policy to a group of healthcare workers, by Mian, Warchal, Whitney, Fitzmaurice, and Tancredi.[258] Findings of this study were consistent with the findings in previous studies on the attitudes of nurses and physicians. The authors concluded that despite the differing concerns of nurses and

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[254] Duran et al., 277.

[255] Duran et al., 277.

[256] Duran et al., 277.

[257] Duran et al., 270.

[258] Patrician Mian, Susan, Warchal, Susan Whitney, Joan Fitzmaurice, and David Tancredi, "Impact of a Multifaceted Intervention on Nurses' Attitudes and Physicians' Attitudes and Behaviors Toward Family Presence During Resuscitation," *Critical Care Nurse* 27, no. 1 (February 2007): 52–61.

physicians, the implementation of a family presence program at Massachusetts General Hospital in Boston was successful and is now the standard of practice in their emergency department.[259] "Nurses are advocates for patients and their families, so it was not surprising that nurses took the lead in initiating implementing a new policy."[260] Again, a hospital began with a collaborative approach to assess the attitudes of their healthcare professionals and introduced FPDR policies for their implementation.

Twibell et al. in 2008 created two new test instruments to measure nurses' perceptions of family presence during resuscitation and to measure the nurses' self-confidence.[261] The research was complex. Twibell et al. believed there to be "three distinct gaps that exist" in what is known about perceptions and decisions of nurses regarding family presence during resuscitation in adults.[262] The gaps included:

> Findings across studies cannot be compared when the survey questions used in the studies differ, making it difficult to build a scientific body of knowledge of family presence. . . . The second gap is due to the lack of conceptual framework. . . . The third gap is due to the types of samples included in earlier research.[263]

The purpose of this study was to address the three gaps and test their new instruments, "The Family Presence Risk-Benefit Scale (FPR-BS)" and "The Family Presence Self-confidence Scale (FPS-CS)."[264] The four research questions for the study were:

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[259] Mian et al., 60.

[260] Mian et al., 60.

[261] Renee Samples Twibell, Debra Siela, Cheryl Riwitis, Joe Wheatley, Tina Riegle, Denise Bousman, Sandra Cable, Pam Caudill, Sherry Harrigan, Rick Hollars, Doreen Johnson, and Alexis Neal, "Nurses Perceptions of Their Self-Confidence and the Benefits and Risks of Family Presence During Resuscitation," *American Journal of Critical Care* 17, no. 2 (March 2008): 101-12.

[262] Twibell et al., 102.

[263] Twibell et al., 103.

- What are the psychometric properties of two new instruments used to measure nurses' perceptions related to family presence?
- What are the relationships between nurses' perceptions of risks, benefits, and self-confidence related to family presence during resuscitation?
- What are the relationships among demographic variables and nurses' perceptions of family presence during resuscitation?
- What are the differences in perceptions of nurses who have and have not invited patients' families to be present during resuscitation?[265]

"A total of "375 nurses" participated in the study, for a response rate of" 64%" [266] "About two-thirds of the participants (n = 254) had never invited the family of a patient to be present during resuscitation, more that 20% (n = 83) had invited family presence at least once but fewer than 5 times, and 7.5% (n = 28) had invited it 5 times or more."[267] Results revealed the "dramatically divergent" responses of the participants reflecting the continuing controversy of the nature of FPDR.[268] Nurses who had high confidence viewed family presences as more beneficial. Other findings indicated that nurses who hold professional certification, work in emergency rooms, and are members of professional organizations are more favorable toward family presence than other nurses.[269] As for the success of the two instruments used in the survey, FPR-BS and FPS-CS, indicated that the scales provide a reliable and valid measures of nurses' perceptions of risk and benefits and self-confidence related to family presence.[270] Further testing of

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[264] Twibell et al., 103.

[265] Twibell et al., 103.

[266] Twibell et al., 103.

[267] Twibell et al., 104.

[268] Twibell et al., 107.

[269] Twibell et al., 107.

[270] Twibell et al., 110.

the instruments would lend to greater reliability and more valid measurements. Twibell et al. closed their publication by stating that "Evidence-based practice will be enhanced as concepts relevant to family presence are identified and measured consistently across studies."[271] Once again, the measurement consistency in the studies had emerged as another common theme during the past few decades.

Four advance practice nurses in Minnesota designed a descriptive and correlational study for support of family presence in their critical care and emergency departments. Basol et al. used the Emergency Nurse's Association Family Presence and Support: Staff Assessment Survey.[272] A trend in the FPDR literature has emerged through projects of various hospitals to research and implement a FPDR policy (Meyers et al. 2000, Mangurten et al. 2005, Duran et al. 2007, and Mian et al. 2008). The Basol et al. findings were very similar to past studies previously listed. This study revealed both support and nonsupport for FPDR and a policy was created to represent both contingencies. The policy was designed to provide an option for the "reluctant healthcare team member to refuse FPDR" and it also provided an opportunity for those who" support FP to invite the family."[273] Additional education is necessary to heighten the awareness of the staff to FPDR and evidence-based practice should be included in the justification. The two most significant outcomes for the study were the written hospital

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[271] Twibell et al., 110.

[272] Roberta Basol, Kathleen Ohman, Joyce Simones, and Kirsten Skillings, "Using Research to Determine Support for a Policy on Family Presence During Resuscitation," *Dimensions of Critical Care Nursing* 28, no. 5 (September/October 2009): 237-47.

[273] Basol et al., 246.

FPDR policy to implement for consistent usage and the repeated use of the ENA research tool.

The last study in this literature review was performed by another group of advanced practice nurses in an Emergency Department in the Michigan, Tomlinson et al. 2010.[274] Their motive was also to research, educate, and implement FPDR and IP in their facilities. The authors used chaos theory to give insight into the behavior patterns of humans during certain situations such as CPR. The questionnaire was distributed to nurses and physicians with a return of "80 completed surveys. This number represented a 40% response rate."[275] Barriers to greater support of FPDR/IP were typical, such as fear of family interference and increased levels of stress to the trauma team. The researchers concluded that despite the fears, most ER registered nurses and staff personnel in their hospital would support adult FPDR.[276] They too, commented that more education of staff is required before there is universal acceptance of the practice – a reoccurring theme in the research of FPDR.

During a thorough literature search, many themes converged regarding the positive effects of FPDR. Regardless of the location of the hospital, staff, and families studied there was a consistency in the outcomes of the research, both qualitative and quantitative.

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[274] Karen R. Tomlinson, Ina J. Golden, Judy Mallory, and Linda Comer, "Family Presence During Adult Resuscitation: A Survey of Emergency Department Registered Nurses and Staff Attitudes," *Advanced Emergency Nursing Journal* 32, no. 1 (February 5, 2010): 46-58.

[275] Tomlinson et al., 49.

[276] Tomlinson et al., 46.

Summation of the positive findings in the literature that support FPDR:

1. The family felt their presence helped and supported the patient.
   (Eichhorn, Meyers, 1998, Meyers 2000, AHA 2000, Doyle, Hanson and Strawser)

2. FPDR helped family deal better with grief.
   (Doyle, Hanson/Strawser, Meyers 1998, Meyers 2000, Robinson 1998, Timmermans, Belanger 1997, Grice, Mangurten 2005)

3. Being present for the resuscitation helped to remove doubt about what was happening to the patient and reinforced to the family that everything possible was being done to assist the patient.
   (Meyers 2000, Doyle, Hanson/Strawser, Robinson 1998, Timmermans 1997, Grice 2003)

4. FPDR reduces anxiety and fear.
   (Robinson 1998, Doyle, Berlanger)

5. FPDR sustains family connectedness and bonding.
   (Meyers 2000, Doyle, Eichhorn, 2001)

6. FPDR provides a sense of closure on a life shared together.
   (Meyers 2000, Hanson/Strawser 1992)

7. Nearly all families involved in FPDR reported that they would make the same choice again.
   (Meyers 2000, Doyle, Belanger 1997)

8. Despite the fears of healthcare providers that patients' families might become emotionally upset and interfere with care, researchers found no disruptions in the operations of the health care team, no adverse outcomes during the events at which patient's families were present.
   (Doyle, Meyers 2000, Hanson/Strawser, Robinson, Belanger, Mangurten 2005, Redley/Hood, Meyers 1998, Eichhorn)

9. No adverse psychological effects occurred among family members who participated at the bedside.
   (Meyers, Robinson, Belanger, Mazur et al, 2006)

10. Benefits to family presence to meet the needs of the patient and family, it has been recommended programs should be developed to offer patient's families the option of being at the bedside during CPR.
    (ENA 1995, AHA 2000, Meyers, Hanson, Robinson, Mitchell, Eichhorn 2002, Clark 2001, Mazur et al, 2006)

11. Nurses generally had more of a positive attitude toward FPDR than physicians. (Chalk, Helmer, Meyers 2000, Bassler, Timmermans, McClenathan et al)

12. Families wanted an option to be present. (Meyers 1998, Eichhorn et al. 2001, Meyers 2000, Robinson, McMahon et al, 2009, Mazur et al, 2006)

13. Families felt they had a right to be present. (Doyle, Meyers 2000, Mazur et al., 2006, Eichhorn et al, 2001)

14. FPDR allowed family to say goodbye. (Doyle, McClement et al 2009)

15. Allowing FPDR is a family-centered approach to patient care. (Meyers 2000, Redley/Hood, Helmer, Chalk)

Summation for negative perceptions studied in the literature.

Many of these perceptions have already been researched and been proven to be misconceptions.

1. Families felt they would get in the way of the code team. (Duran, Tomlinson, Meyers 2000, Redley/Hood, Mangurten)

2. Code team members preferred family exclusion from code room because of fear that families would become emotional and interrupt the resuscitation. (Eichhorn, Redley/Hood, Timmermans, Helmer et al.)

3. The resuscitation would be too traumatic for family members.(Meyers 2000, Redley/Hood, Helmer, McClenathan, Ellison, Duran)

4. There is a lack of staff to meet the needs of the family while in the resuscitation room. (Helmer 2000, Hanson/Strawser)
5. Insufficient space in the resuscitation room to accommodate the family. (Hanson/Strawser, Helmer, MacLean 2003, Robinson 1998)

6. Having FPDR would increase litigation. (Redley/Hood, Meyers 2000)

7. FPDR is a violation of the patient's confidentiality and privacy. (Helmer 2000)

8. Potential that provider's technical skill would be affected because providers were uncomfortable with family member's presence.
   (Eichhorn 1996, Hanson/Strawser, Doyle et al., Timmermans, Berlinger, Redley/Hood, Helmer, Chalk)

9. FPDR would pose negative psychological effects upon the family members.
   (Meyers 2000, Redley/Hood, Helmer)

10. Families were not aware that they could be present in the resuscitation room.
    (Meyers et al 1998, Eichhorn, Meyers 2000, Robinson)

The summation of the positive and negative findings obtained from the FPDR literature since 1987 is helpful when planning for future research. Understanding where the FPDR gaps of information and impairments to implementation of policies provides insight for future research possibilities.

The purpose of the next chapter introduces professional ethics as they pertain to the physician, patient, and family surrounding the concept of FPDR. Discussion of the ethical concepts will illuminate the importance of the patient and the family in the decision-making process surrounding resuscitation. Patients and families must be given resuscitation information that will assist them in making their end-of-life decisions.

CHAPTER 2

MEDICAL ETHICS

Ethical concepts guiding this study include beneficence, paternalism, and autonomy. Admittedly, these concepts will be applied equally to both the family and the patient. The patient becomes incapacitated during resuscitation, rendering any decision-making to be done by the physician and/or family. Family should be allowed the opportunity to be present during resuscitation if they desire, not a decision made only by the physician managing the resuscitation. Typically, the physician managing the resuscitation is a resident who is not familiar with the patient or the family. Perception of most families is that they are not allowed in the resuscitation room, as they will interfere or disrupt the resuscitative procedures.[277] It is imperative that the family understands the importance of their right to choose whether or not to be present during resuscitation. This decision could have long-lasting negative or positive effects upon the family members. Patients and families have the most vested interest in the outcome of the resuscitation and should therefore, have the authority to make informed decisions regarding FPDR.

Healthcare continues to be challenged by many changes in its delivery, advanced technology, consumer needs, and fiscal demands. "Today legal protection, financial gain and academic reputation for research and innovation are arguably as central to the actual practice of medicine as the doctor-patient interaction, which is under threat from mechanization, as well as the context and content, of the practice and delivery of care"[278]

[277] Meyers et al., 1987.

[278] Katherine Wasson and E. David Cook, "Pellegrino and Medicine: A Critical Revision," *The American Journal of Bioethics* 6, no. 2 (March/April 2006): 90.

"Doctors often practice defensive medicine, seeking to protect themselves or their institution from lawsuits, rather than protecting the patient."[279] Defensive medicine results in decisions that may lack fiscal responsibility and often not meet the needs of the patient. Medical students are aware of their actions and may focus more on possible litigation, rather than focusing on the moral decisions they are faced within their patient care.[280] Changes in medicine over the past few decades have made the role of the physician more ambiguous. Patients and their families are more determined to have their needs met through a vast amount of information made available to them through the media and technology.

Further changes have occurred in the study of ethics. We are approaching medicine through a different or more modern viewpoint. During the most recent decades there have been changes in what is considered the ideal model for the relationship between the physician or healthcare provider and patients. The dated model of care in "[p]aternalistic models have been replaced by models in which more emphasis is placed on respecting patient freedom and sharing decision making."[281] "Controversy still exists, however, about which non-paternalistic model is best and how far providers should involve themselves in influencing the patient's values, goals, and decisions."[282] Edmund Pellegrino, world-renown physician and ethicist, writes, "[i]n today's pluralistic society, universal agreement on the moral issues between physicians and patients is no longer

[279] Wasson and Cook, 90.

[280] Wasson and Cook, 90.

[281] Center for Health Ethics University of Missouri School of Medicine, "The Provider-Patient Relationship," http://ethics.missouri.edu/Providers-Patients.aspx (accessed June 10, 2011).

[282] Center for Ethics University of Missouri School of Medicine.

possible."[283] Pellegrino believes that medical ethics is based upon the philosophy of the healing relationship between the patient and the physician, and that "[ethics] is a formal, rational, systematic examination of the rightness or wrongness of human actions."[284] Ethical issues arise when a moral system becomes "problematic and is challenged."[285] In a simpler time the image of the physician was that of a compassionate and intelligent man or woman in a white coat who was 'all-knowing' and were expected to make the best decisions for all of their patients. The physician was highly respected, revered and extremely devoted to their patients. Pellegrino believes at the center of medical morality is the healing relationship which is defined by three phenomena; "the fact of illness, the act of profession, and the act of medicine."[286] Because of illness the patient has lost some of their freedom and has become vulnerable and dependent in the relationship with the physician. Physicians have the necessary knowledge to treat the patient and the empowerment by the patient to make vital life and death decisions. "One of the realities of illness is the gap in the information that separates the patient and the physician. Certainly one of the physician's obligations is to close the gap, to enhance the patient's capability to act and make truly human decisions."[287]

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[283] Edmund D. Pellegrino, "Toward a Reconstruction of Medical Morality," *The American Journal of Bioethics* 6, no. 2 (March/April 2006): 65-71.

[284] Pellegrino, 65.

[285] Pellegrino, 65.

[286] Pellegrino, 65.

[287] Pellegrino, 68.

Pellegrino believes "[t]he physician has a responsibility to discuss the moral questions so that the patient can act in a way consistent with their own belief system."[288] Careful attention on the part of physician must be made so that his beliefs or values are not forced upon the patient.[289] Imposing the physician's personal value system upon the patient is often very difficult to avoid because the physician's vast experience with previous patients has shaped his or her own education and values. Patient's limited knowledge of medicine and their immediate medical condition can compromise their own decision-making capacity. Recognition of the difference between professional values and an individual physician's personal values is of the utmost importance in professional relationships.[290] Personal value systems of the physician is often difficult to discern when he/she is making the best possible decisions for so many different patients. Professional and personal experiences of the physician dictate many of their moral decisions.

Patients and families, as consumers have become more educated, medicine more complicated, and the relationship between the patient and the physician more distant or non-existent. Bridging the changing gap of older interpretations and newer ethical applications provides a foundation for the discussion of FPDR and some of the ethical principles. Ethical principles that are involved in FPDR include: beneficence, paternalism, and autonomy. An understanding of these principles can better explain a more realistic and mutually beneficial relationship between physician, patient and family.

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[288] Pellegrino, 68.

[289] Pellegrino, 68.

[290] Pellegrino, 68.

Understanding the importance of ethical principles in decision-making will ultimately benefit all the participants in the resuscitative process, including family and loved ones.

Beneficence

Let us begin with the ethical principle of beneficence. Beauchamp and Childress are considered some of the foremost experts on the writings in definition and application of the ethical principles. Their definitions of the ethical principles will be used throughout this chapter. "*Beneficence* refers to the *character trait* of *virtue* of being disposed to act for the benefit of others. *Principle of beneficence* refers to a statement of moral *obligation* to act for the benefit of others."[291] When caring for a patient, Beauchamp and Childress claim that it is not enough that we " . . . refrain from harming them, but that we also contribute to their welfare."[292] "Throughout the history of health care, the professional's obligations and virtues have generally been interpreted as commitments of beneficence."[293] The famous Hippocratic work of *Epidemics* states succinctly, "As to disease, make a habit of two things—*to help, or least to do no harm*."[294] Beauchamp and Childress maintain "…that there is an implicit assumption of beneficence in all medical health care professions and their institutional contexts: Promoting the welfare of patients –not merely avoiding harm—embodies medicines' goal, rationale, and justification."[295]

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[291] Beauchamp and Childress, 197.

[292] Beauchamp and Childress, 197.

[293] Beauchamp and Childress, 207.

[294] *Epidemics*, 1:11, in Hippocrates, vol. I, ed. W.H.S. Jones (Cambridge, MA: Harvard University Press, 1923): 165.

[295] Beauchamp and Childress, 205.

Physicians 'own interpretation to the "help" and "to do no harm" rests in their own set of morals and sense of right and wrong. In past practice, the patient and their families deferred many decisions to the doctor who perhaps had known the family most of their lives. In those earlier times, the physician, family and patient were less transient. The image of the physician was viewed as one of authority and distinction. Medicine as a profession has long been held as a virtuous and highly respected career that many would argue has changed in the last few decades. The role of the physician is no longer as definitive.

Beauchamp and Childress "present two principles of beneficence: positive beneficence and utility."[296] "*Positive beneficence* requires agents to provide benefits to others."[297] "*Utility* requires that agents balance benefits, risks, and costs to produce the best overall results."[298] Many times these principles may conflict with one another. Although the patient may benefit by a singular medical choice – society's scarce resources and prohibited medical costs may decide differently for the patient. Technical advances of the past few decades have made the choices to extend life very costly to society. The nation's resources are limited. If a physician chooses to extend life because of the sophistication of the equipment we have to ask the question of, 'just because we can, should we?'

[296] Beauchamp and Childress, 197.

[297] Beauchamp and Childress, 197.

[298] Beauchamp and Childress, 197.

Beauchamp and Childress use of the principle of positive beneficence to support "an array of moral rules of obligation."[299] Examples of their rules for beneficence:

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
3. Help persons with disabilities.
4. Rescue persons in danger.[300]

In the discussion of medical ethics, healthcare professionals examine, with the patient and the family, what impact the intervention or treatment may have upon the patient, both positively and negatively. Procedures or intervention should not be done if healthcare professionals truly believe that the risks outweigh the benefits. Beneficence requires taking action by helping " . . . prevent evil or harm, remove evil or harm, and to do or promote good."[301] Seeking the family's understanding of FPDR and the possible positive outcomes should be part of the discussion in promoting good for both the patient and the family. Ultimately, the decision rests with the patient, surrogate, or closest family member. In the case of FPDR, the family's need for presence should take precedence over the physician's needs or concerns in the a code room. Traditionally, the decision of FPDR would fall upon the physician. Many times the physician performing the resuscitation had never met the patient and the family. Robert Veatch writes that today's physician "may know something of the patient's medical condition and perhaps even know what is medically important to the patient, but cannot know most of what commands primary place in the patient's total life picture. There is inequality of

[299] Beauchamp and Childress, 199.

[300] Beauchamp and Childress, 199.

[301] Beauchamp and Childress, 151.

knowledge of a different kind in which the physician is in a uniquely poor position to know what is important."[302]

Not only has the participation of the physician, patient, and family changed, but some of the moral foundations of medicine have been realigned due to many factors, such as litigation. Physicians are forced to practice defensive medicine which further complicates the doctor/patient relationship. Other factors affecting the practice of present-day physicians may include "financial gain and academic reputation for research and innovation."[303] All of these factors affect the ability of the physician to make the decisions that are in the best interest of the patient. Medical morality of the healing relationship and interaction with the patient, described by Pellegrino, has already deteriorated.[304] Thus, the ethical principle of beneficence, which is founded in the "promoting good for the patient, preventing harm or removing harm," becomes greatly diluted and doubted by the patient.[305] "Physicians have a responsibility to underscore the moral questions so that the patient can act in a way consistent with his or her belief systems. Clearly, the physician must avoid imposing his own values on the patient."[306] Traditionally, physicians relied upon their own professional and personal judgments in decision-making for the patient. Recently those methods have been challenged by the

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[302] Robert M. Veatch, "Assessing Pellegrino's Reconstruction of Medical Morality," *The American Journal of Bioethics* 6, no. 2 (March/April 2006): 74.

[303] Wasson and Cook, 90.

[304] Wasson and Cook, 90.

[305] Beauchamp and Childress, 151.

[306] Pellegrino, 68.

patient regarding individual rights and the problem of physician paternalism.[307] As the patient has become more educated in making their own choices through patient's rights, self-determination, and autonomy, the role of the physician has been forced to change dramatically. Medical paternalism in healthcare relationships with the physician and the patient holds the physician in a superior role of expertise, greater knowledge, and insight into the disease and is " . . . thus in an authoritative position to determine the patient's best interests."[308] This perspective places the physician into a paternalistic role with the patient. Pellegrino and Thomasma suggest that the gap of paternalism and autonomy can be facilitated by a concept known as "beneficence-in-trust."[309] "By beneficence-in-trust we mean that physicians and patients hold 'in trust' (Latin, *fiducia*) the goal of acting in the best interest of one another in the relationship."[310] The importance of this concept is to create a relationship with the patient, physician, and family when possible.

Paternalism

Paternalism is defined by Beauchamp and Childress " . . . *as the intentional overriding of the person's preference or actions by another person, where the person who over-rides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden.*"[311]

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[307] Beauchamp and Childress, 207.

[308] Beauchamp and Childress, 208.

[309] Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988): 54.

[310] Edmund D. Pellegrino and David C. Thomasma, 54.

[311] Beauchamp and Childress, 208.

Paternalism may be understood by a reference to the parental relationship of a father to a child in decision-making concerning best-interest.[312] H.L.A. Hart has defined paternalism in its simplest form as "the protection of people against themselves."[313] Throughout our history " . . . paternalism was the dominant, and indeed the accepted, model of the clinical relationship . . ."[314] "Paternalism was not as ethically dubious in times past as it is today."[315] "Medical paternalism asserts that the physician unequivocally knows better than the patient as to what is "good" for her."[316] During the last few decades many physicians have not had a relationship with the majority of their patients due to an increase in medical specialties, consultants, and the transience of people. Neither the patient nor the physician may have much opportunity to know one another beyond a diagnosis. The days of the close ties of physician, patient, and family are dwindling. There is, of course, difficulty when the physician is forced to make decisions in patients' best interest' and they have little knowledge of the "person" as their patient. Physicians are then forced to make decisions based upon what they believe is the common good rather than the individualization of those choices. "Under the best interest standard a surrogate decision maker must determine the highest net benefit among the

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[312] Tom L. Beauchamp, "Medical Paternalism, Voluntariness and Comprehension," *Ethical Principles for Social Policy,* ed. John Howie, (Carbondale, Ill: Southern Illinois University Press, 1983): 124.

[313] H.L.A Hart, *Law, Liberty, and Morality* (Stanford: Stanford University. Press, 1963): 31.

[314] Pellegrino and Thomasma, 13.

[315] Pellegrino and Thomasma, 13.

[316] Pellegrino and Thomasma, 24.

available options . . . "[317] " . . . [B]est interest judgments are meant to focus attention entirely on the value of the life for the person who must live it, not the value the person's life has for others."[318] Opportunities for family to make these decisions becomes very complicated because of their personal issues in the matter of the patient and whether the decisions made are in the best interest of the patient or in the best interest of the family. End-of-life issues become particularly complex because family members often lack the insight into the patient's best interest or quality of life that may be chosen based upon end-of-life decisions. The physician, patient, or family can interpret best interest differently. The problem continues to increases in its complexity.

Beauchamp believes that "[p]aternalism seems to pervade modern society, for many actions, rules, and laws are commonly justified by appeal to a paternalistic principle."[319] Some of the examples of paternalism which supersedes the wishes of the patient and/or family include; court orders for blood transfusions for the Jehovah Witness, involuntary court-ordered commitment for the psychiatric patient, "rational suicides," denial of experimental drugs or therapies for individuals wishing to seek alternative methods of treatment, or resuscitating patients who have asked not to be resuscitated.[320] Although many of these types of decisions may have been grounded in the moral principle of beneficence " . . . not everything flowing from a beneficent motives is commendable; and limiting the liberty of the beneficiaries is often flatly

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[317] Beauchamp and Childress, 138.

[318] Beauchamp and Childress, 140.

[319] Beauchamp, 123.

[320] Beauchamp, 123.

unwelcome because of the apparent invasion of autonomy. Paternalism is the issue generated by this conflict of principles."[321]

Beauchamp posits that " . . . the paternalism in the medical profession has been under attack in recent years, especially by the defenders of patient autonomy."[322] He states "these defenders of patient autonomy" believe physicians "intervene too often" on behalf of the patient and "assume too much control over the their choices of their decisions."[323] Patients have become more informed through the media, Internet, and changing relationships with physicians. Both family and patients often do not trust the opinion or the values of the physicians they may have been assigned to based upon their insurance or the call rotation of the physicians covering the emergency room or hospital. The consumer of healthcare has simply become more informed.

"Philosophers and lawyers have tended to support the view that autonomy is the primary factor in the patient/physician relationship . . ."[324] Those that argue in defense of paternalism suggest physicians encounter patients who simply cannot comprehend the content of the decisions they must make and the physician must guide the patient to a decision of best interest. In this case, the physician would be exercising "soft paternalism" which Beauchamp and Childress consider " . . . the actions that pursue the values that they believe the intended beneficiary holds but cannot realize because of

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[321] Beauchamp,123.

[322] Beauchamp,124.

[323] Beauchamp,124.

[324] Beauchamp,124.

limited capacities, commitment, or limited self-control."[325] Family members may prefer the physician withhold a terminal diagnosis to the patient as it will cause the patient to lose hope, create depression, or diminish any positive outcomes for the final days of life. These situations place the physician in a very precarious position, especially when they are not familiar with the patient. The patient's need or right to know their diagnosis versus the family believing that knowledge of the diagnosis will have devastating effects creates an ethical dilemma of autonomy versus paternalism.

Beauchamp writes that arguments opposing paternalism " . . . even limited paternalistic rules or policies can easily be abused and will inevitably lead to serious adverse consequences when put into practice."[326] "Those concerned about paternalism in medicine cite abuses that may result from latitude of judgment granted by paternalism to physicians or other medical professionals."[327]

Legal changes benefiting the patient and their ability to make decisions in their care were greatly influenced the United States in 1991 by the Patient Self-Determination Act. The Patient Self-Determination Act gave hospitalized patients the right to make treatment decisions, which later led to the formation of advanced directives.[328] Advance directives require the patient to make decisions about their end-of-life care, including the right to refuse life-sustaining treatment. Patients are realizing that their failing health requires a close examination of their physical, psychological, social, and spiritual needs.

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[325] Beauchamp and Childress, 210.

[326] Beauchamp, 131.

[327] Beauchamp, 131.

[328] Beauchamp and Childress, 9.

When a patient realizes the end of their life is imminent, often times they look to repair broken or disrupted relationships and final meaning in their lives. Patients' active participation at the end of their life further complicates the earlier concept of the doctor-patient relationship and in many instances creates more controversy.

Pellegrino and Thomasma site the infamous court case of Karen Ann Quinlan that debates paternalism:

> One of the most influential tests of the traditional paternalistic model of the patient-doctor relationship occurred in the Karen Ann Quinlan case. In that case, the Supreme Court of New Jersey ruled that the state's interests (and medical interests) in keeping a person alive are superseded in irreversible situations by a person's wishes—in Quinlan's case, previously she expressed wishes not to remain on a life-support system, such as a respirator.[329]

"Soft paternalism" refers to situations whereby an agent, physician ". . . intervenes in the life of another person on the grounds of beneficence or nonmaleficence with a goal of preventing substantially *nonvoluntary* conduct."[330] The use of soft paternalism and weak paternalism are often used interchanageably. Examples of nonvoluntary actions would include cases of an incomplete or poorly executed informed consent or an addicted patient, who at the time, is unable to make an informed decision.[331] In soft paternalism cases, the physician becomes obligated to make decisions for the patient because the patient is unable to make an informed decision of their own due to a situation beyond their present control; traumas, medication, alcohol, or changes in consciousness. Beauchamp and Childress maintain that " . . . soft paternalism does not

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[329] Pellegrino and Thomasma, 5.

[330] Beauchamp and Childress, 209.

[331] Beauchamp and Childress, 210

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involve a real conflict between principles of respect for autonomy and beneficence."[332] The category of soft paternalism has been a far more popular theory in both law and moral philosophy, holding that ". . . individual's self-regarding conduct can be restricted only when it is substantially nonvoluntary or substantially uninformed."[333] Examples of such paternalism would include; a patient under the influence of psychotropic drugs, sepsis, or unable to grasp the severity of the diagnosis or emergency based upon the technical circumstance of the illness or procedure, severe pain rending the patient unable to make decision, or a head injury altering a fully conscious decision.[334] All of these examples affect the memory and judgment of patients in medical situations that " . . . significantly compromise a patient's voluntariness or understanding."[335] These patients may maintain some capacity to make judgments and exhibit some capacity for voluntary action and consent. "Drug addicts, the mentally ill, and the patients with strongly conditioned habits can even be categorized by partial capacity and partial incapacity for long periods of time."[336] Soft paternalism, in this instance would hold " . . . that a person's autonomy or liberty may be limited because his or her capacity for autonomous action is severely restricted."[337] Many of the interventions defended by the soft paternalists are clearly justified and are in the patient's best interest.[338] "Soft paternalists

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[332] Beauchamp and Childress, 210

[333] Beauchamp, 134.

[334] Beauchamp, 134.

[335] Beauchamp, 134.

[336] Beauchamp, 134.

[337] Beauchamp, 134.

recommend policies and actions that pursue the values that they believe the intended beneficiary holds but cannot realize because of limited capacities, commitment, and limited self-control."[339] Decisions are made for the patient by using what the physician believes to be in the best interest of the patient. The analogy often used for illustration in soft paternalism is that of the relationship between a father and his child, whereby the father makes decisions for the minor based upon his personal values and the best interest of the child.[340]

Hard paternalism or strong paternalism raises substantially more controversy in medical ethics.[341] "Strong paternalism restricts information and overrides the informed and voluntary actions of individuals where information and actions significantly affect only the individuals themselves."[342] The actions of hard paternalism are considered to be those that " . . . display disrespect toward autonomous agents and fail to treat them as moral equals, treating them instead as less–than-independent determinators of their own good."[343] Pellegrino and Thomasma believe that "[s]trong paternalism is objectionable not only because it violates moral rules, but because it violates the architectonic aim of medicine, which is to heal the one who is ill."[344] Beauchamp and Childress maintain that,

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[338] Beauchamp, 134.

[339] Beauchamp and Childress, 210.

[340] Beauchamp, 134.

[341] Hard paternalism and strong paternalism are used interchangeably.

[342] Beauchamp, 133.

[343] Beauchamp and Childress, 213.

[344] Pellegrino and Thomasma, 23.

"hard paternalism in healthcare can be justified if the following conditions are satisfied when:

A patient at risk of a significant, preventable harm.
The paternalistic action will probably prevent the harm.
The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
There is no reasonable alternative to the limitation of autonomy.
The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted.[345]

"Paternalism, where the doctor knows best and makes decisions for the patient, has gone out of fashion in favor of models emphasizing patient autonomy."[346] Paternalistic models have been replaced by models placing more emphasis on respecting patient freedom in choice and sharing decision-making with the physician, patient and family. Expanding the definitions and combining the ethical principles may offer the physician, patient, and family greater choices and decisions. Pellegrino and Thomasma believe that, "[m]odern medicine incorporates moments of patient choice as well as moments of necessary, beneficial paternalism."[347]

Autonomy

Respect for autonomy is considered one of the most fundamental concepts for medical ethics. Beauchamp and Childress provide a well-respected definition. "Personal autonomy encompasses, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding

[345] Beauchamp and Childress, 216.

[346] Wasson and Cook, 90.

[347] Pellegrino and Thomasma, 14.

that prevents meaningful choice"[348] The controlling influence of an individual in context of our discussion may be the paternalistic physician who has decided that there will be no family in the resuscitation room based upon the physician's need or personal opinion of FPDR, not the opinion or need of the family.

"Virtually all theories of autonomy view two conditions as essential for autonomy: *liberty* (independence from controlling influences) and *agency* (capacity of intentional action)."[349] "Respect for autonomy is not a mere *ideal* in health care; it is a professional *obligation*. Autonomous choice is a *right*-not-*duty*-of patients."[350] Childress writes, "the conditions for autonomous choice must be distinguished from the ideal of autonomy. It is important for the moral life, that people be competent, informed, and act voluntarily."[351]

Patient autonomy has become a more popular topic in medicine especially as it relates to paternalism. Not long ago, most major medical decisions were left exclusively in the trusted hands of physicians. Their decisions were considered beneficent but perhaps not always made with full disclosure or discussion with the patient.[352] With an increased value placed upon patient autonomy and new generations of medical training in a more "patient-centered" approach, the decision-making in the clinical setting has

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[348] Beauchamp and Childress, 99.

[349] Beauchamp and Childress, 100.

[350] Beauchamp and Childress, 107.

[351] James F. Childress, *Practical Reasoning in Bioethics* (Indianapolis: Indiana University Press, 1997): 60.

[352] Alireza Bagheri, "News and Views: Regulating Medical Futility: Neither Excessive Patient's Autonomy Nor Physician's Paternalism" *European Journal of Health Law*15 (2008): 48.

dramatically changed.[353] Consumers have become more participatory in the decisions and discussions surrounding their own care both in healing and end-of-life decisions. "Appealing to 'patient autonomy' has prevailed in court rulings, and has consequently influenced and reshaped doctor-patient relationships."[354] "To violate the patient's autonomy is to deprive him or her of one essential component of her own good, and thus to violate medicine's promise to act for the good of the patients."[355] "Physicians have become more passive in their patients' care and many feel that giving patients a full range of choices and withholding their own recommendations are safeguards against lawsuits."[356]

Pellegrino and Thomasma believe "a new balance between autonomy and beneficence" must occur in the physician/patient relationship and that the "central moral principle in the ethics of medicine is beneficence."[357] They maintain " . . . that the patient seeks not only to be protected from harm, but also to be healed and to have health restored or improved, pain and anxiety relieved, disability lessened."[358] Pellegrino and Thomasma agree that "medicine is to restore autonomy" and "concern for autonomy must be tempered by the impact of the disease upon the patient."[359] They further clarify:

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[353] Bagheri, 48.

[354] Bagheri, 48.

[355] Pellegrino and Thomasma, 23.

[356] Bagheri, 48.

[357] Pellegrino and Thomasma, vii and viii.

[358] Pellegrino and Thomasma, vii.

[359] Pellegrino and Thomasma, 6.

> Nevertheless, there are weaknesses in both autonomy and paternalism models when they are applied to a relationship as complex as the medical relationship. Paternalism overrides the dignity and humanity of the patient; autonomy overrides the concern we should show for the helping each other, especially if we belong to a group ordained by society specifically to help in the special human circumstances we call illness.[360]

Despite the growing popularity of consumer's rights, the principles of respect for individual autonomy, self-determination, and freedom of choice in the discussion of healthcare decisions, many of the patient and family needs are not being heard or met. Specific to the topic of FPDR, the individual's right to remain with their relative following a sudden life-threatening event continues to be a debatable topic rather than an acceptable norm surrounding patient and family-centered care. "The hallmark of any ethical decision-making process with regard to justifying an individual's right to witness resuscitation is the mutually interactive process of communication which assists relatives in making an informed, voluntary decision regarding presence."[361]

As healthcare professionals we are obligated to deliver family-centered care that maintains open communication and honest interaction that will best suit the interests of the patient and their family. The needs of the patient and family are changing and requiring the process of self-determination and autonomy. Allowing the family the opportunity to attend the resuscitation of their loved one may benefit the family in many ways. It is not the decision of the code team to allow FPDR, but the informed decision of the family members. Knowledge for the family can be empowering. Obligation of the healthcare professional is aimed at sharing knowledge with the vulnerable individual so

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[360] Pellegrino and Thomasma, 6.

[361] Wendy Marina Walker, "Do Relatives Have a Right to Witness Resuscitation*", Journal of Clinical Nursing* 8 (1999): 629.

as to empower that person to reassert control and make the best decision for themselves or in this case, the family.

" . . . [T]he hallmark of any ethical decision-making process with regard to justifying an individuals right to witness resuscitation is the mutually interactive process of communication which assists relatives in making an informed, voluntary decision regarding their presence."[362] A relative's request to remain with their loved one during resuscitation is a very personal decision and continues to prompt debate. Exploration of fundamental ethical principles is valuable in relation to justifying a relative's right to witness resuscitation. The principle of respect for autonomy guides us to address the values and the goals of the family members of the patients we resuscitate.

Families making autonomous decisions regarding FPDR must have accurate information, not just emotion. There is published evidence for both opposing and advocating FPDR. The evidence presented must be tested and proven from past practice. Reasons for opposition to FPDR include: healthcare providers not asking families to be present; fear of psychological trauma to the family; fear that families cause distraction and compromise patient outcomes; and fear that families might interfere with the healthcare team's resuscitative efforts.[363] "Other issues raised include medical-legal concerns involving increased litigation; lack of space; lack of appropriate family chaperones; performance anxiety; fear of appearing inexperienced or incompetent; safety

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[362] Walker, 629.

[363] Christopher T. Doolin, Lisa D. Quinn, Lesley G. Bryant, Ann A. Lyons, and Ruth M. Kleinpell, "Family Presence During Cardiopulmonary Resuscitation: Using Evidenced- Based Knowledge to Guide the Advanced Practice in Developing Formal Policy and Practice Guidelines," *Journal of the American Academy of Nurse Practitioners* 23 (2011): 10.

of the patient or the patient's family, and confidentiality risks."[364] Cumulative reasons given by the previous studies for advocating FPDR include, fostering a trust between the family and the healthcare professional, helping families to understand the severity of the patient's critical condition, promoting more professional attitudes of the healthcare personnel, meeting some of the emotional needs of the family, lending closure, and beginning the process of grieving for the family.[365] Other positive effects of FPDR include: witnessing that everything was done to save their loved one's life, an opportunity to say goodbye, a decrease in the dark humor of the code team - portraying a more professional demeanor of the team; the family's anxiety was decreased, and the dignity, wishes, and privacy of the patient were respected.[366]

Clearly, the needs of the patient and family should take precedence over the code teams' discomfort. Advocating for the family in FPDR has progressed but requires more public knowledge and understanding. "The literature review suggests a growing trend for acceptance, if not endorsement, of FPDR in the hospital setting."[367]

The discussion of this chapter offers the healthcare professional an ethical and philosophical standard of practice for the patient and the family in FPDR. Weighing the ethical principles of paternalism, autonomy, and beneficence can help eliminate ambiguity for the healthcare professional and assist them in the important decision-making with the family.

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[364] Doolin et al, 10.

[365] Doolin et al, 10.

[366] Doolin et al, 10.

[367] Doolin et al, 9.

Chapter three presents the methodology of the study based upon the literature review and the ethical principles chosen in this study. An original questionnaire tool was comprised of many of the findings in the literature review and a description of the population was chosen.

CHAPTER 3

METHODOLOGY

Research regarding FPDR has been limited to the study of code team members in a hospital setting, or those who have had medical education or direct experience in the resuscitation practices. Many of the research studies about FPDR have been launched in an effort to persuade the hospital staff to participate in FPDR through the use of hospital protocols. Research in the field of the public's perception or ideas regarding FPDR is very limited.

The purpose of this study was to determine if exposure to factual information about FPDR positively influences the FPDR perceptions of the lay public. This is the first study to use a large sample of respondents outside of the medical environment. This survey pretests the public on their knowledge and perceptions of the practice of FPDR, provides factual information retrieved from previous research studies, and post-tests the participants using the same questions to identify changes in their thinking about FPDR.

Limitations

Limitations of this study are common to self-administered surveys. Convenience samples gathered were not a representative sample. Because participation was voluntary, it poses a self-selection bias. Respondents may represent those who have strong opinions about the issues, or may represent those with more time available to participate in the survey. This original questionnaire was devised through a literature review, not a standardized questionnaire tool. Therefore, this questionnaire was limited in terms of reliability and validity because it has not been tested beyond this researcher. The majority

of the sample surveyed was college-educated, fifty-five percent. Outcomes for this group may be more informed about the topic of FPDR. Two other limitations in the demographics portion of the survey were the age and education categories. Age categories could be expanded for more detailed information so the data can better capture the influence of age in relation to the survey responses. Further limitations were in the level of education categories that can be divided into more categories to also achieve more detailed information in the demographic responses. The category of high school or less, could be divided into two separate categories, such as less than a high school education and completed high school. Also the category of college could be divided into three categories; trade school, college, and graduate school. Further limitations were related to two of the survey questions regarding spirituality and patient privacy. Responses for both of these questions were not captured for 103 of the respondents.

Research Questions

The research study questions were based upon the varying demographics, public perception and knowledge of FPDR, and life experience related to experiencing family death and personal end-of-life planning. Data analysis will study the effect of the factual information given in the survey by the comparison of the pretest choices and the posttest choices using a Likert scale questionnaire. The study research questions are:

1. Do different demographic groupings have different perceptions concerning FPDR?
2. Does factual information regarding resuscitation influence the general public's perception concerning FPDR?
3. Does experiencing a loved one's death influence the general public's perception of FPDR?

4. Does being present at a loved one's death influence the general public's perception of FPDR?
5. Does end-of-life planning influence the general public's perception of FPDR?

Survey Method Plan

This study was done through the use of a self-administered quantitative pretest – posttest original research tool. The use of an original tool was needed because of the limited number of research studies done with the lay public. Marco and Larkin's research studies in 2003 were focused on the public. In their study the participants were shown an eight-minute educational video to portray factual information regarding resuscitation. The participants were resurveyed to determine the influence of factual information given to them as lay public.[368] Marco and Larkin also used a self-administered survey developed to determine knowledge, opinions, and personal preferences regarding CPR among the lay public as a pre-intervention tool. The next public survey was done in 2008, performed by Marco and Larkin to further identify accuracy and knowledge, and to determine opinions of the general public regarding cardiopulmonary resuscitation.[369] Improved public education regarding resuscitation and heightened efforts to improve communication regarding resuscitation preferences were recommended by Marco and Larkin.[370]

[368] Marco and Larkin, 2003, 490.

[369] Marco and Larkin, 2008, 256.

[370] Marco and Larkin, 2003, 494.

This research study was designed for the lay public, to deliver information in a written paragraph and to examine different topics.[371] Also, the study was designed to measure the influence of previous experience with death and plans for end-of-life. There have not been any other research studies done with the lay public to measure the impact of life experience upon the individual and their knowledge of FPDR.

Because the questionnaire was original there was no established reliability or validity. However, it was based on a careful review of the literature. The research questionnaire was distributed to four different populations using Survey Monkey. Survey Monkey, an Internet-based company, provided several advantages for research; the economy of design, rapid turnaround in data collection, computerized data gathering, anonymity for more candid responses, privacy, lack of interviewer bias, and the computer analysis rather than human error of manual data retrieval. Seventeen-pretest questions/comments and the seventeen posttest questions/comments were the same. Factual compilation of information was gathered from previous research studies in FPDR and the factual information is the independent variable of the survey. Attitudes of the participants were the dependent variables and the intervening variables were the demographic data. The questionnaire was comprised of several comments and questions used in previous studies, as well as original questions. Each response of the participant was compared to his or her own pretest and posttest response to measure the influence of the factual statement given after the pretest questionnaire.

[371] Berger, Brody, Eisenstein, and Pollack, 2004. Portions of the educational paragraph from this survey were used to explain the resuscitation process for the layperson.

Instrumentation

A Likert scale was chosen for this original survey.[372] The questionnaire tool was new so it is important that a larger sample be surveyed so there is more ability to generalize concepts and better investigate causal relationships between the independent, dependent, and intervening variables. The goal of the researcher was to obtain a minimum of 300 completed surveys. Survey Monkey was utilized so that a larger sample could be reached.[373]

The survey consisted of six parts: the introductory letter, demographics questionnaire with three brief life-experience questions, a brief introduction to the topic of FPDR, and seventeen original questions. A five-point Likert scale from: strongly agree, agree, disagree, strongly disagree to not sure was chosen[374] The matrix questions offered an efficient format for presenting a set of closed-ended questionnaire items that have the same responses.[375] The fifth portion of the survey was a half-page of factual information regarding FPDR, drawn from the literature review. The last section of the questionnaire was a repeat of the original seventeen questions to compare whether or not the factual information influenced the respondents' answers.

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[372] Denise F. Polit and Cheryl Tatano Beck, *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (New York: Lippincott, Williams & Wilkins, 2008): 757. A Likert scale is a composite measure of attitudes involving the summation of scores on a set of items that respondents rate for their degree of agreement or disagreement."

[373] Survey Monkey obtains their population through volunteers whose demographics match those requested by the Survey Monkey customer. Respondents are not paid, however, they have an opportunity to give fifty cents for each survey completed to a charity of their choice. Also, respondents are eligible to win contest prizes. Use of Survey Monkey services are at a cost of one dollar per survey obtained.

[374] John W. Creswell, *Research Design Qualitative, Quantitated, and Mixed Methods Approaches,* 3rd ed. (Los Angeles, CA: Sage Publications Inc., 2009), 148.

[375] Babbie, 471.

The introductory letter is produced in full in the appendix. It identifies the purpose of the study and a short explanation of the topic using general terminology so the respondent can understand the subject matter.[376] The respondents were asked to answer each question based upon their own opinion, knowledge, or feelings toward the topic of FPDR. There is no correct answer. The respondent's opinion may have been based upon life experience, exposure to hospital settings, friend or family death, literature they have read or contact with various forms of media.

Demographics

Section two of the study was a general demographics section. The respondent was asked to check off categories of age, gender, marital status, educational level, ethnicity/race, and religious affiliation. The final three questions were more personal and specific which request a simple response of yes or no:

1. Have you ever had a close friend or immediate family member die?
2. Have you ever been present at the time of death of a close friend or immediate family member?
3. Have you ever made your end-of-life wishes known to anyone?

These final three questions were designed to make determinations of the participant's exposure to death and end-of-life planning. Responses were intended to explore the research questions inquiring whether those individuals with more exposure to death and end-of-life planning would be more likely to make an autonomous decision to consider FPDR.

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[376] Introductory letter can be found in Appendix 1.0.

Part three of the survey document was designed to provide the respondents more information about the process of cardiopulmonary resuscitation in the hospital setting. The explanation included what a family member might be exposed to during resuscitation if they are in the room with the healthcare professionals. Appropriate language was used to make the concept of resuscitation more understandable to the layperson. The respondent was later asked to respond to seventeen comments related to FPDR.

Introducing the Topic

> The following questions are related to this study on hospital patients who require CPR (cardiopulmonary resuscitation) that is given when a patient suddenly stops breathing or their heart stops beating. A team of specially trained nurses, physicians, and respiratory therapists perform CPR. CPR usually involves heavy pressing on the chest which can break the patient's ribs, shocking the chest with electricity, placing a breathing tube into the throat, and inserting needles and tubes into the veins of the arms, neck, or groin. Patients are rarely awake during CPR. The procedures usually require that all of the patient's clothes be removed. Sometimes close family members may have the opportunity to be with their hospitalized loved one during the life-saving emergency involving CPR. Please answer the following questions regarding your opinion of family presence during CPR using the following scale. Your answers are not right or wrong. We simply want to know what you think.

The Presurvey and Postsurvey Questions

1. The CPR team can deny family in the room during CPR.
2. I would like to have my loved one with me if CPR was performed on me.
3. I think it would be too traumatic for me to be present with my family member during the CPR.
4. I think it would reassure my family member if I was at their bedside.
5. Being with my loved one during CPR would be a spiritual experience for me.
6. I need to stay out of the way so the CPR team can do their job.
7. I don't think the emergency team would want me there.
8. I have a right to be with my family member in any situation.
9. I don't know if I could emotionally handle watching CPR.
10. I want to be able to touch my loved one during the CPR process.
11. Because my loved one is not awake, they wouldn't know if I was there anyway.

12. I would need to be there to make sure everything was being done to save my loved one's life.
13. I would rather be in another room with the other family members waiting for the CPR team to finish.
14. I think most hospitals would allow family members to be present during resuscitation.

15. I think it is an invasion of a patient's privacy to have family members present.
16. The CPR team could perform their duties better if family members were not watching them.
17. My family member has a high probability of not surviving CPR.

Factual Information

Allowing family to be present during CPR is a controversial subject and is handled differently from hospital to hospital. Only 15 -18% of in-hospital patients survive the emergency CPR and they are more likely to die than to survive CPR. Some families today believe it is their right to be present during CPR and are exercising that right. Only 5 % of the hospitals across the United States have written policies for family presence during CPR, so it becomes the decision of the individual CPR team to allow family presence during the emergency CPR. The family presence studies conducted over the past 25 years have concluded that there are many positive aspects of family presence during CPR such as:

a) allows opportunity for family member to support and comfort their loved one
b) reduces fear and anxiety that everything possible was done to save their loved one's life
c) provides a sense of closure on their lives together
d) helps facilitate the grieving process the family member
e) encourages more professional behavior of the CPR team
f) reminds the CPR team of the patient's personhood
g) provides an opportunity to educate the family member about the patient's condition

These facts have been given to you to see if this information may influence your decision-making in the future regarding family presence during resuscitation. The same questions will be asked of you on the next page.

The short paragraph was composed to give the respondent factual information regarding FPDR based upon research over the past twenty-five years. As stated in the

hypothesis, the factual information was intended to inform the respondents, which may affect their perceptions and possible future autonomous decision-making. Validation of the factual information was referenced in the literature review chapter.

The final part of the survey repeated the first seventeen questions in the pretest to compare whether or not the factual information presented in part five influenced the participant's responses. Statistical analyses included paired t-tests to determine if differences were statistically significant.

Rationales for Questionnaire Compilation

Each of the questions/comments composed for this questionnaire was based upon numerous research findings from the literature review.

1. The CPR team can deny family in the room during CPR.

Question one was designed to establish whether or not the respondent has any knowledge as to whether or not the family is allowed in the resuscitation room. Previous research has demonstrated that most families were unaware that they could have the opportunity to attend the resuscitative efforts of their loved one.[377] Today some families are allowed in the resuscitation room because of their awareness of the opportunity through previous hospital experience or knowing someone with a healthcare background. Some hospital personnel may offer FPDR. Few hospitals have a formal FPDR policy in place so FPDR is inconsistent and infrequent. However, all too often the decision to allow family presence disseminates from the code team rather than the family.

[377] Meyers et al, 1998; Eichhorn, Meyers et al., 2000; Robinson.

2. I would like to have my loved one with me if CPR was performed on me.[378]

A family presence comment is designed to elicit whether or not the participant may have ever given this topic thought or consideration. If the respondent had prior knowledge of FPDR or had a close member of the family die during resuscitation they *may* be more likely to request a family member present if they should require resuscitation.

3. I think it would be too traumatic for me to be present with my family member during the CPR.[379]

This comment may establish a fear of personal trauma while viewing resuscitation. The response provided a baseline of the individual's belief about CPR. Although the topic of trauma for the family has been studied numerous times in the past research, families may still be resistant. Previous studies have not identified any adverse psychological side effects from FPDR.[380]

4. I think it would reassure my family member if I were at their bedside.[381]

The respondent's opinion during the pretest could indicate past experience with a close friend or family member at the end-of-life. This past experience could influence their behaviors surrounding FPDR or an opportunity to measure the influence of the factual statement upon the posttest. Previous research suggests that the families believed that the patient perceived their presence. The majority of patients researched, albeit a small number, during their own resuscitation believed that the presence of their family member

[378] Benjamin and Holger; Mazur; Cox and Capon.

[379] Ellison; McClenathan; Duran.

[380] Meyers, 1998; Robinson; Belanger; Mazure et al., 2006.

[381] Mazure, Cox, and Capon; Duran; Eichhorn; Meyers, 1998; Meyers, 2000; AHA 2000; Doyle, Hanson, and Strawser, 1987.

or close loved one was helpful and supportive.[382] Studies are very limited in the number of patient's surviving CPR with family presence.

5. **Being with my loved one during CPR would be a spiritual experience for me**.[383] This comment was designed to determine if there was any correlation between a religious affiliation and a positive response to FPDR. Unfortunately, the terminology of spirituality is unclear for the respondent. Religion and spirituality are two different terms that are too open for interpretation. Not all respondents were given the opportunity to respond to this comment. During the retrieval of the data, it was discovered that the respondents at Luther College and Drew University were not given the spiritual question in the survey through the Survey Monkey process. Therefore, there was 103 or 23.3 percent of the respondents missing from the spirituality question. Upon discovery of the missing question it was too late to gather the missing data. The exact cause of the missing comment was never determined to be the author's or Survey Monkey's. To correct this missing data in future research, I would recommend a closer follow-up with the Survey Monkey process and additional review of the survey.

6. I need to stay out of the way so the CPR team can do their job.[384]

Many individuals are not aware there may be an opportunity to be in the resuscitation room. Some individual's may believe that they would only be in the way of the code team or their presence does not offer any consolation for the patient. Further, families

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[382] Mazure, Cox, and Capon; Duran; Eichhorn; Meyers, 1998; Meyers, 2000; AHA 2000, Doyle, Hanson, and Strawser, 1987.

[383] Meyers et al, 2000; Eichhorn. Question not included in all surveys.

[384] Meyers et al.,1987; Duran; Tomlinson.

may not know any of the personal advantages of being in the code room. This is a statement posed to determine what possible assumption the respondent may adopt regarding the CPR team. Previous studies have shown there are no adverse outcomes or interferences as the result of family presence during a hospital resuscitative code situation.[385]

7. I don't think the emergency team would want me there.[386]

Is the selection by the respondent based upon a family or personal need versus the needs of the code team? Previous research in FPDR regarding the opinions of the code team staff indicates that the majority of code team members do not wish to have the family present during resuscitation.[387] More physicians than nurses are likely to have a negative attitude toward FPDR.[388]

8. I have a right to be with my family member in any situation.[389]

Does the respondent have knowledge of patient/family rights and patient/family needs? What is the relationship between formalized education and understanding of patient's rights? Research indicates that families felt they had a right to be present.[390]

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[385] Doyle and Meyers, 2000; Hansen and Strawser; Robinson; Berlanger; Mangurten, 2005; Redly and Hood; Meyers, 1998; Eichhorn.

[386] Redley and Hood; Mangurten; Tomlinson.

[387] Meyers et al., 1987; Duran;Tomlinson.

[388] Meyers, Eichhorn, and Guzzetta.

[389] Meyers, Eichhorn, Guzzetta,1998; Mazure, Cox. and Capon; Duran; Eichhorn.

[390] Meyers et al., 1987; Duran; Tomlinson.

9. I don't know if I could emotionally handle watching CPR.[391]

How does the respondent perceive their emotional strength? Does the respondent have any perceptions of the patient's needs that may supersede their own? Research findings supporting FPDR indicate that family presence actually reduces anxiety and fear of the family member.[392]

10. I want to be able to touch my loved one during the CPR process. [393]

This comment is designed to explore how important it may be for the loved one to attend CPR and indicate whether or not the respondent felt it was important to the family member or self. Research studies reinforce that families felt their presence helped and supported the patient.[394]

11. Because my loved one is not awake, they wouldn't know if I was there anyway.

Many people believe that patients are unable to sense or hear during an unconscious or resuscitative episode. The factual statement specifically clarified to the respondent that patients are often able to sense and hear the presence of a loved one, as well as the code team.[395]

12. I would need to be there to make sure everything was being done to save my loved one's life.[396]

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[391] McClenathan.

[392] Doyle, Berlanger, Robinson, 1998.

[393] Hansen and Strawser.

[394] Eichhorn and Meyers, 1998; Meyers, 2000; AHA 2000; Doyle, Hanson, and Strawser.

[395] Mazure, Cox, and Capon; Duran; Eichhorn; Meyers 1998; Meyers 2000; AHA 2000, Doyle, Hanson, and Strawser 1987.

[396] Meyers et al., 2000; Duran, and Doyle, 1987.

Respondents in this category may have needed reassurance and some control over the resuscitative efforts for their loved one. Research supports that being present for the resuscitation removes doubt about what was happening to the patient and reinforced to the family that everything possible was being done.[397] Family members may believe that the code team "didn't try hard enough" or "gave up too soon" during the code.[398]

13. I would rather be in another room with the other family members waiting for the CPR team to finish.

This statement was designed to determine what the respondent felt they should do or what they were most comfortable in choosing for the situation. A family remaining in another room while the patient is being resuscitated is the traditional protocol.

14. I think most hospitals would allow family members to be present during resuscitation.

How much baseline knowledge does the respondent have about the topic of FPDR and hospital policy? Only five percent of United States hospitals have written policies addressing FPDR.[399] Opportunity for families to be present during CPR varies greatly from hospital to hospital and code team to code team.

15. I think it is an invasion of the patient's privacy to have family members present.

This comment was designed to elicit whether or not privacy was an issue as indicated in the presurvey explanation. Not all respondents were provided this comment in the survey.

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[397] Meyers, 2000; Doyle, Hanson and Strawser; Robinson,1998; Timmermans, 1997; Grice, 2003.

[398] Comments received from family members during professional experiences with families during resuscitative measures, both in the code room and in the waiting room.

[399] MacLean, 2003.

During the retrieval of the data, it was discovered that the respondents at Luther College and Drew University were not given the privacy question in the survey through the Survey Monkey process. Therefore, there were 103 or 23.3 percent of the participants missing on the privacy question. Upon discovery of the missing question, it was too late to gather the missing data. The exact cause of the missing comment was never determined to be the author's or Survey Monkey's.

16. **The CPR team could perform their duties better if family members were not watching them.** [400]

During the literature review this was a common response from families believing the code team would do a better job if family was not watching the code team.[401] The team felt that they were at greater risk for litigation.[402] Do the respondents choose to stay out of the code room because of their personal needs or because of the perceived needs of the code team?

17. Most patients survive CPR in the hospital and return home.

This comment will elicit a perception of the respondent. There are many misconceptions about resuscitation and survival brought on by television and the media. Only fifteen to eighteen percent of in-hospital patients survive the emergency CPR to make a healthy

[400] Chalk, Timmermans, and Doyle, 1987.

[401] Eichhorn 1996; Hanson and Strawser; Doyle et al.: Timmermans; Berlanger; Helmer; Redley and Hood.

[402] Redley and Hood; Meyers, 2000.

return home. Patients are far more likely to die than survive CPR.[403] The factual statement clarifies this misconception.

Pilot Study Plan

An eight-person group without medical training or healthcare experience was chosen for pretesting the questionnaire. Five males and three females were chosen from my community. They were all familiar with me and understood I was beginning research and requested their input. Their ages ranged from twenty-six years to fifty-five years. Following the completion of the trial survey, the individuals were asked to respond to the following:

- Identify parts of the instrument package that are difficult to read, understand or could be misinterpreted.
- Identify any questions that might find objectionable, offensive, or too emotional
- Determine whether the sequencing of questions on the instrument are sensible.[404]
- Describe other comments that would be helpful for the readability of the questionnaire.

The pretest group was very informative and offered several editorial, content and clarification questions on the survey. Pilot respondents estimated the time to take the questionnaire was about ten minutes and they felt the length was appropriate and the content very informative. They commented that they had never known it was possible to be in the CPR room and found the topic to be "very interesting." Responses of the pilot group were utilized to modify the survey for the main study.

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[403] Marco and Larkin, 2008; Timmermans.

[404] Polit and Beck, 380.

Sample Selection Process

Four different groups were surveyed following the review of the pilot study. Both males and females were queried with a starting age of eighteen years to seventy or older. Subdivisions of the categories of age difference was broadened, suspecting that the older age group may have more opinions and experience about death than the younger age categories. All of the respondents were required to read English. People less than eighteen years old were excluded because of limited life experience. Two college populations were given the survey, one with undergraduate students only and the other institution had undergraduates and graduates. Because there were only 103 surveys completed by the two institutions, Survey Monkey was obtained to gather a minimum of 350 other participants. These two categories consisted of high school or less education, 199 and college education, 141. Further detail of each group is discussed below.

Survey Sample D: Drew University

Drew University is a small liberal arts college in Madison, N.J. The college consists of both graduate and undergraduates students in liberal arts studies and graduate studies with a combined enrollment of 2,581. Drew University was chosen because the author was in attendance for graduate study. Distribution of the questionnaire through the campus webmail was also approved by the Caspersen School of Graduate Studies. Students in both the undergraduate and graduate programs were voluntarily instructed to connect to the link on Survey Monkey and given the instructions listed earlier in the chapter. A reminder webmail was sent to the student body three weeks later. Eighty-two graduate and undergraduate students completed the survey, three percent.

Survey Sample L: Luther College

Luther College is a small liberal arts college located in Decorah, Iowa where the author had previously taught in the baccalaureate nursing program. The college enrollment is 2600 that includes the 105 nursing students who were sent the link to the survey through campus electronic mail. The nursing students were sophomore and junior level with very limited medical education. The college IRB chairman approved the survey and the department head of nursing also approved the questionnaire to be sent to nursing students during their summer break through the School of Nursing's webmail system. Nursing students were sent a reminder for the survey two weeks after the initial request. Twenty-one surveys were completed, twenty percent.

Survey Monkey Sample H (high school or less) and C (college)

Survey Monkey was retained to distribute the survey to two different groups of individuals. One group was requested for people who have a high school or less education and group two was composed of college education individuals. Group H consisted of individuals who had a high school or less level of education, 199 surveys completed. Group C was comprised of individuals who had a minimum of college education. One hundred forty-one surveys were completed.

Data Analysis Plan

The preanalysis phase of the data involved a careful review of the information for completeness, assignment of identification numbers, and designing a coding system. The software for the analysis phase was the Statistical Package for Social Science (SPSS). First, the data was carefully coded. Then, the options for analysis were made to combine

categories giving more flexibility and opportunity for detail or generality.[405] There were no open-ended questions in the survey so coding was relatively efficient. All of the data was entered into the computer file and assessed for quality and missing data.[406] When data was missing from the questionnaire, a determination was made as to whether or not there is sufficient remaining data available to perform analysis using the variables. In some of the cases, participants needed to be excluded from the analysis because some of the missing data was considered too essential for the final analysis of the survey.[407] A research associate at Rutgers University was obtained for assistance in coding and analyzing the data.[408]

Chapter Four presents the detailed data analysis with discussion. Section I of the data retrieval process will include the individual demographic response rates using a simple distribution table of the four samples previously listed as; H, L, D, and C. A demographic frequency table for the six demographic variables of age, gender, marital status, education, ethnicity, and religion will present the frequencies of each category. The last portion of Section I will present the levels of significance using Pearson's Chi-Square to identify the level of significance of relationship to each demographic item as it relates to the presurvey and post survey questions.

Section II presents the three questions asked at the end of the demographic portion requiring the use of Chi-square: 1. Have you ever had a close friend or

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[405] Babbie, 406.

[406] Polit and Beck, 643.

[407] Nancy Burns and Susan K. Grove, *Understanding Nursing Research*, 3rd ed. (Philadelphia, PA: Saunders, 2003): 312.

[408] Dr. Peijia Zha, Ph.D., Research Associate, Rutgers University.

immediate family member die? 2. Have you ever been present at the time of death of a close friend or immediate family member? 3. Have you ever made your end-of-life wishes known to anyone? Chi-square analyses will be used to compare those that answered, "yes" or "no" to any of the seventeen questions to observe if the respondent's life experience may or may not have affected their responses. Chi-Square analyses indicate the level of significance of each yes/no questions.

In section III the respondents were compared to themselves by using a paired t-test to determine if differences between pretest and posttest responses are statistically significant. The levels of significance will be the alpha as indicated by .05*, .01**, and .001*** with the .001 to be the most significant level.[409] "The minimum acceptable level of alpha usually is .05. A stricter level (e.g., .01 or .001) may be needed when the decision has important consequences."[410] These three levels of significance were utilized throughout the data analysis.

Chapter four provides the data from the questionnaire tool that is necessary to draw correlations based upon the data and the tests chosen for data analysis. Additional data may be found in the appendix. There will be a discussion about the demographics and life experience's influence upon the answers in the questionnaire, followed by a critical analysis of the questionnaire tool.

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[409] Babbie, 465.

[410] Polit and Beck, 588.

CHAPTER 4

RESULTS AND DISCUSSION

The FPDR questionnaire was distributed to four different populations from March 2010 through October 2011. Survey distributions were sent to Drew University and Luther College. A return from the two colleges represented a modest number of 101 completed surveys. Survey Monkey was contracted to retrieve additional surveys to achieve a higher number of respondents. The total number of respondents from Survey Monkey was 340 participants. Ultimately, a total of 443 surveys were used for the analysis, with an overall return/completed rate of seventy-seven percent as illustrated below in Table 1.0, response rates. Because many of the previous studies done in FPDR had been limited in the number of participants and input from the general public, the goal was to achieve a minimum of four hundred respondents.

Table 2.0 Response Rates by Group

Sample Group	**Surveys Completed**	**% Response**	**% Total**
Group H Survey Monkey High School/Less	199	79.3%	44.9%
Group L Luther College Undergraduate	21	66.7%	4.7%
Group D Drew University College/Graduate	82	73.6%	18.5%
Group C Survey Monkey College	141	76.9%	31.8%

Table 2.1 Demographic Frequencies

	n	%	Total
Age			433
21-39 years	168	38.7%	
40-59 years	196	45.2%	
60-70 years	70	16.1%	
Over 70	0	0	
Gender			434
Female	176	39.7%	
Male	267	60.3%	
Marital Status			443
Single	162	36.6%	
Married	223	49.2%	
Divorced or Separated	49	11.1%	
Widow	9	2.0%	
Education			433
High School or Less	199	46.0%	
College/Graduate School	234	54.0%	
Ethnicity			439
Caucasian	365	83.1%	
African American	31	7.1%	
Asian/Pacific Island	10	2.3%	
Hispanic/Latino	20	4.6%	
Multi-racial	13	3.0%	
Religious Affiliation			423
Atheist/Agnostic	84	19.9%	
Christian	328	77.4%	
Jewish	9	2.1%	
Hindu	2	0.5%	
Buddhist	0	0	
Muslim	0	0	

The average respondent in this survey was a Caucasian, married male between the ages of forty and fifty-nine years old. The respondent had a college or greater education with a Christian affiliation.

Section I - Demographic Information

The following section provides both demographic and statistical data regarding the respondents. Cross-tabulations in the SPSS program were used to examine the relationship between the demographic variables and the seventeen-pretest and posttest questions. Pearson's Chi-Square was used to determine the level of significance of the relationship between the demographic item and the numbered questions. A complete set of the data can be found in the appendix.

Age

The study design had grouped ages of the respondents, showing the majority of the respondents to be in the age grouping of forty to fifty-nine years old, 45.2%. Second largest age group to respond was the twenty-one to thirty- nine-year-old category, 38.7%. While I am unable to draw an exact comparison based upon the age-groupings, the clear majority of the responders, 83.9% fall between the ages of twenty-one to fifty-nine years old. [411]

The age category was compared to each of the seventeen questions to identify any areas of statistical significance. While this data does not explain how the questions are affected by the demographic variant, the information simply signifies a level of statistical sensitivity. The statistical figures identify a numerical correlation, which does not imply

[411] http://www.census.gov/population/age/data/2011comp.html, Table 1 Population: 2011, Mean age. Retrieved June 13, 2013. The 2011 United States census identifies an overall national mean age of 36.8 years old; females to be 38.1 years old and male to be 35.5 old.

causation. Correlation refers to how closely the two sets of data are related.[412] Only three of the seventeen survey questions identified a significant level of sensitivity to age as seen below. In the pretest, Q -13 (I would rather be in *another room* with the other family members waiting for the CPR team to finish.) showed statistical significance, p = 0.005**[413]. In the posttest Q-2, (I would like to have my *loved one with me* if CPR was performed on me.) p = 0.002** and also posttest Q -15 (I think it is an invasion of a patient's *privacy* to have family members present.) p = 0.013*.

Table 4.0 Pre Survey and Post Survey - Age[414]

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q2. I would like to have my loved one with me if CPR was performed on me.	12.16	.144	24.82	.002**
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	21.83	.005**	6.04	.533
Q15. I think it is an invasion of privacy to have family members present.	4.36	.82	19.46	.013*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

The age of the sample respondents has very little statistical significance.

Gender

There is a greater percent of male than female respondents in the study, with sixty percent and nearly forty percent, respectively. [415] The demographic variable of gender

[412] Polit, 272.

[413] Formula for abbreviated for presentation of statistical information: χ^2 = the chi-square; and p = measured level of significance. The standard set is 0.5*; 0.1** or 0.001***, which gives the researcher more confidence that the relationship of the results of the sample actually exist in the general population.

[414] Complete age data can be found in Appendix; Table 2.2, 2.3, and 4.0.

suggested a minimal number of questions that reflected statistical significance as seen in the table below. Gender sensitivity was identified in three pretest questions: Q-1 (The CPR team can deny family in the room during CPR.) Q-9 (I don't know if I could emotionally handle watching CPR.), and Q-11 (Because my loved one is not awake, they wouldn't know if I was there anyway.) The only gender sensitive question in the posttest is Q-11 (Because my loved one is not awake, they wouldn't know if I was there anyway.), which was consistent with statistical significance in the pretest question eleven.

Table 4.1 Pre Survey and Post Survey - Gender[416]

		Pretest		**Posttest**	
		χ^2	**P-value**	χ^2	**P-value**
Q1.	The CPR team can deny family in the room during CPR.	9.62	.047*	.84	.993
Q9.	I don't know if I could emotionally handle watching CPR.	12.44	.014*	7.74	.101
Q11.	Because my loved one is not awake, they wouldn't know if I was there anyway.	10.76	.030*	11.96	.018*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Although gender in general terms was not identified as being a strongly significant variant, four of the questions showed statistically significant sensitivity to gender, primarily in the pretest questions.

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[415] http://www. census.gov/population/www/cen2010/glance/index.html>. Retrieved June, 12, 2013. The 2010 Census Summary File 1 (SF1)contains data on age, sex, race, etc. Source: United States Census Bureau. The 2010 Census Summary File 1, 1 – 15. The United States average gender census documents a 49.2 percent male population and a 50.8 percent as female population.

[416] Complete gender data can be found in Appendix; Table 2.4, 2.5 and 4.1.

Marital Status

The marital status of the average survey respondent was a married person at 49.2 percent. The single respondent was found to be 36.6 percent of the survey group. The combined married and single groups represented 85.8 percent of respondents.[417]

Marital status sensitivity was shown in two presurvey questions and two posttest questions. Q - 4 (I think it would reassure my family member if I were at their bedside.) and Q - 7 (I don't think the emergency team would want me there.) In the posttest results the significance was shown in Q - 5 (Being with my loved one during CPR would be a spiritual experience for me.) and Q -12 (I would need to be there to make sure everything was being done to save my loved one's life.). Pretest Q - 4 (I think it would reassure my family member if I were at their bedside.) showed the highest level of significance of all four statistically significant questions.

Table 4.2 Pre Survey and Post Survey – Marital Status[418]

		Pretest		Posttest	
		χ^2	P-value	χ^2	P-value
Q4.	I think it would reassure my family member if I was at their bedside.	31.56	.002**	14.60	.327
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	12.65	.395	21.65	.042*

[417] http://www.census.gov/compendia/statab/cats/births_deaths_marriages_divorces/marriages_and_divorces.html; chapters 131,132,133. Obtained July 20, 21023. Marital Status of the Population by Sex, Race and Hispanic Origin: never married 26.9%, married 56.4%, widow 6.3%, divorced 10.4%. The United States census indicates the average citizen is married at 56.4 percent, which is approximately a seven percent difference than the survey's demographic data.

[418] Complete marital data can be found in Appendix; Table 2.6, 2.7 and 4.2.

Table 4.2 Pre Survey and Post Survey – Marital Status[419]

	Pretest		Posttest	
	χ^2	P-value	χ^2	P-value
Q7. I don't think the emergency team would want me there.	23.38	.025*	13.96	.304
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17.55	.130	21.14	.048*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

As with age and gender, marital status also does not appear to be statistically significant in general terms.

Education

For the purposes of a more accurate data compilation, the educational levels were divided into only two categories; high school and/or less education at forty-six percent and college and/or graduate school at fifty-four percent. The survey had an almost three percent higher number of high school or less participants and about one percent higher in the combined college and graduate school educated individuals. Differences in the figures between the survey averages and the national averages did not appear to be significant.[420]

The demographic of educational level showed the most statistical sensitivity of all the other demographic areas. Education sensitivity was shown in four pretest questions and six posttest questions. According to the survey, three of the statistically significant questions were seen both in the pretest and the posttest: Q -12 (I would need to be there

[419] Complete marital data can be found in Appendix; Table 2.6, 2.7 and 4.2.

[420] http://www.census.gov/hhes/socdemo/education/data/cps/2012/tables.html, Table 1 Educational Attainment of the Population 18 Years and Over by Age, Sex, Race, and Hispanic Origin, 2012. Obtained June 13, 2013. The United States Census information of 2012 indicates that 43.2 percent of the nation has had a high school education or less. Those who have some or completed college is 48.4 percent and a much smaller population has been in graduate school, 8.4 percent.

to make sure everything was being done to save my loved one's life.), Q -16 (The CPR team could perform their duties better if family members were not watching them.), and Q -17 (My family member has a high probability of not surviving CPR.) Of all of the questions, the most significant one involved the need to make sure everything possible was done for the loved one. Although the demographic of education exhibited the highest number of statistically significant questions, the overall category for purposes of research was not considered statistically significant.

Table 4.3 Pre Survey and Post Survey - Education[421]

		Pretest		**Posttest**	
		χ^2	**P-value**	χ^2	**P-value**
Q1.	The CPR team can deny family in the room during CPR.	2.18	.703	9.71	.046*
Q2.	I would like to have my loved one with me if CPR was performed on me.	11.90	.018*	5.11	.276
Q4.	I think it would reassure my family member if I was at their bedside	9.26	.055	10.37	.035*
Q7.	I don't think the emergency team would want me there.	0.47	.976	13.60	.009**
Q12.	I would need to be there to make sure everything was being done to save my loved one's life.	13.72	.008**	9.56	.049*
Q16.	The CPR team could perform their duties better if family members were not watching them.	9.81	.044*	11.84	.019*
Q17.	My family has a high probability of not surviving CPR.	13.09	.011*	11.05	.026*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

[421] Complete education data can be found in Appendix; Table 2.8, 2.9 and 4.3.

Ethnicity

The majority of the respondents were Caucasian, 83.1 percent. Minority respondents were identified in smaller percentages than the United States census reports.[422] Although both the study and the census reflected a large majority to be white or Caucasian, the minorities in the study were less representative than the United States population percentages.

Ethnic sensitivity was identified in in two of the pretest questions shown: Q - 5 (Being with my loved one during CPR would be a spiritual experience for me.) and Q - 11 (Because my loved one is not awake, they wouldn't know if I was there anyway.) Three posttest questions were significant: Q - 6 (I need to stay out of the way so the CPR team can do their job.); posttest Q -12 (I would need to be there to make sure everything was being done to save my loved one's life.); and posttest Q -16 (The CPR team could perform their duties better if family members were not watching them.)

Table 4.4 Ethnicity: Chi-Square Pre and Post[423]

	Pretest		**Posttest**	
	χ^2	**P-value**	χ^2	**P-value**
Q5. Being with my loved one during CPR would be a spiritual experience for me	30.97	.013*	18.45	.298
Q6. I need to stay out of the way so the CPR team can do their job.	23.97	.090	36.25	.003*
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	29.18	.023*	16.26	.435

[422] www.census.gov/.../estimates_and_projections_by_age_sex_race...US Census Bureau : Estimates and Projections by Age, Sex, Race/**Ethnicity, Table 6 2009. Retrieved June 21, 2013.** 36.3 percent of the population belongs to a racial and ethnic minority group**.**

[423] Complete ethnicity data can be found in Appendix; Table 2.10, 2.11, and 4.4.

Table 4.4 Ethnicity: Chi-Square Pre and Post[424]

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.45	.422	30.27	.017*
Q16. The CPR team could perform their duties better if family members were not watching them.	23.41	.103	32.10	.008**

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Drawing conclusions upon these statistics were limited to the number of ethnic backgrounds represented in the study. There was no overall statistical significance in the demographic of ethnicity.

Religious Affiliation

The final demographic characteristic concerned religious affiliation. The research results were similar to the 2012 United States Census.[425] The vast majority of Americans who claim a religious affiliation in the census named "Christianity" by 75.1percent. The survey reflects 77.4 percent majority as Christian. Nearly twenty percent of the respondents reported themselves as atheist or agnostic, which reflects the more recent national trend in religious affiliation.

Sensitivity to questions according to religious affiliation was shown in pretest Q - 1 (The CPR team can *deny* family in the room during CPR.). There were no posttest

[424] Complete ethnicity data can be found in Appendix; Table 2.10, 2.11, and 4.4.

[425] *www.census.gov › The 2012 Statistical Abstract › Population*; national Data Book; Population Table 75 Self-Described Religion Identification 2008. P. 61. Retrieved June 13, 2013. US Census Christian (including Catholics) 75.1% ; No religion, atheist, or agnostic; 15%; Jewish 1.2%; Muslim 0.6%; Buddhist 0.5%; Hindu 0.3%.

questions with significant sensitivity between religious affiliation and the survey questions.

Table 4.5 Pre Survey and Post Survey – Religious Affiliation[426]

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q1. The CPR team can deny family in the room during CPR.	22.30	.034*	16.44	.189

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Religious affiliation in this study was the least statistically significant of all the demographic areas.

Section I -Demographic Discussion

All of the demographic data showed some limited statistical significance in pretest and posttest questions, but not enough to draw any conclusions. The data did indicate information for study research question one: do different demographic groupings have different perceptions concerning FPDR? This study showed a very limited amount of demographic influence upon the way the respondent answers the pre-survey and post-survey questions; therefore, we cannot conclude that demographic differences impact the survey question responses.

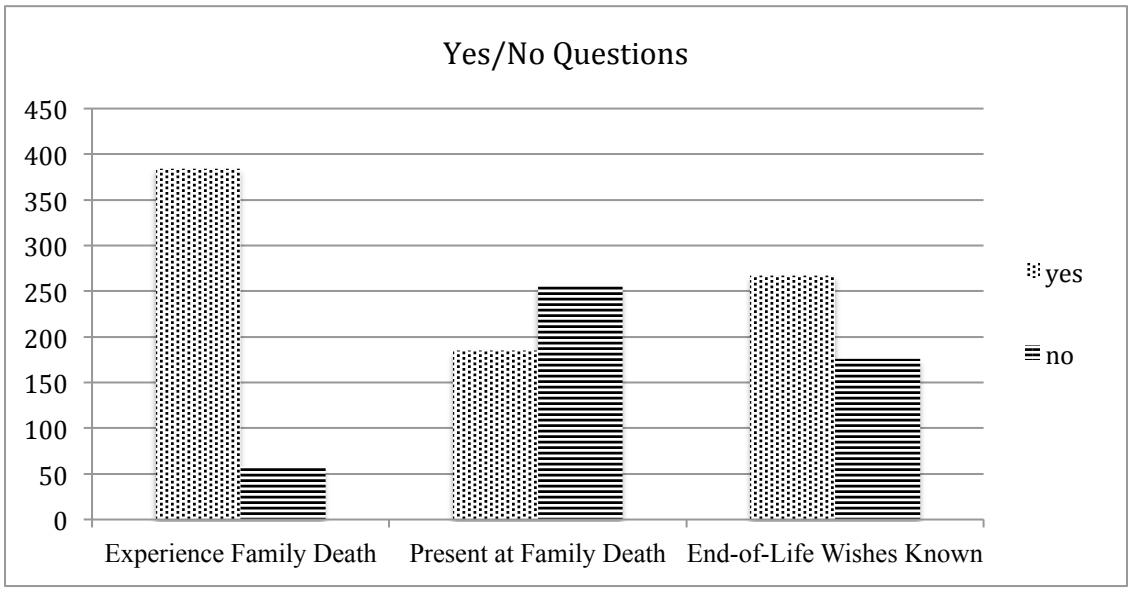
Section II – Life Experience

The next section presented answers to the three-yes/no questions that appeared on the demographics portion. Questions referred to: experience with family/friend death; presence at the family/friend actual death; and participation in formal or informal

[426] Complete religion data can be found in Appendix; Table 2.12, 2.13, and 4.5.

personal end-of-life planning. The chi-square inferential statistic was used to investigate the correlation between experience, presence, and end-of–life wishes as it corresponds to the presurvey and post survey questions.

Table 4.9 Total Yes/No Responses to Questions of Experience, Presence, Wishes



Experienced Family Death

Most of the respondents, eighty-seven percent, have experienced the death of a family member or close friend. Only one question on the pretest showed statistical significance, Q - 16 (The CPR team could perform their duties better if family members were not watching them.) $p = 0.019$*. The vast majority of respondents who answered "yes" to be present for family death, agreed with the need to stay out of the CPR process because they felt that the team could perform better without their presence. The shift of thinking in the posttest results indicated the respondent's change of thinking following the education paragraph, but was not considered statistically significant. This change of

thinking corresponded with previous research done by the Duran et al. study, 2007 concluding that patients and their families had positive attitudes toward FPDR, family members felt it was their right to FPDR, wanted to be reassured that everything was done for their loved one, and obtain a better understanding of the severity of illness.[427]

Those who had experienced family death in posttest Q - 2 (I would like to have my loved one with me if CPR was performed on me.) p = 0.030* are more likely to want a loved one present during resuscitation. This information indicated the educational statement influenced the participant who has experienced family death. Their behavior would be different if they were in a position to make a choice whether or not they should have a loved one present during their own CPR. Those who had experienced family death, after reading the factual information, are more likely to choose to be present for CPR.

In the posttest Q - 6 (I need to stay out of the way so the CPR team can do their job.) p = 0.005**, people who had experienced a family death show significant change in their perception. The respondents were more likely to rethink or change their opinion that they need to stay out of the way of the CPR team. Their presence during CPR appeared to be more important for their loved one than the need to stay out of the CPR team's way.

Table 4.6 Experience Family Death – Chi Square[428]

		Pretest		**Posttest**	
		χ^2	**P-value**	χ^2	**P-value**
Q1.	The CPR team can deny family in the room during CPR.	4.87	.301	3.95	.413
Q2.	I would like to have my loved one with me if CPR was performed on me.	3.94	.413	10.68	.030*

[427] Duran et al., 277.

[428] Complete "Experience Family Death" data can be found in Appendix; Table 2.14 and 2.15.

Table 4.6 Experience Family Death – Chi Square[429]

	Pretest		Posttest	
	χ^2	P-value	χ^2	P-value
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	8.20	.085	8.58	.072
Q4. I think it would reassure my family member if I was at their bedside	2.48	.647	8.61	.072
Q5. Being with my loved one during CPR would be a spiritual experience for me.	2.48	.648	3.26	.515
Q6. I need to stay out of the way so the CPR team can do their job.	5.82	.260	14.89	.005**
Q7. I don't think the emergency team would want me there.	7.35	.119	6.97	.138
Q8. I have a right to be with my family member in any situation.	3.69	.449	1.02	.906
Q9. I don't know if I could emotionally handle watching CPR.	6.82	.146	4.87	.301
Q10. I want to be able to touch my loved one during the CPR process.	6.64	.156	2.61	.624
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	3.26	.516	4.73	.316
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	4.29	.368	2.46	.651
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	6.50	.165	3.83	.430
Q14. I think most hospitals would allow family members to be present. during resuscitation.	6.21	.184	2.78	.595
Q15. I think it is an invasion of privacy to have family members present.	1.27	.866	7.07	.123
Q16. The CPR team could perform their duties better if family members were not watching them.	11.73	.019*	1.93	.749
Q17. My family has a high probability of not surviving CPR.	2.17	.705	2.57	.63

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

[429] Complete "Experience Family Death" data can be found in Appendix; Table 2.14 and 2.15.

Present at Family Death

The respondents who answered “yes” on the question regarding presence at a family member or close friend’s death comprised forty-two percent of those surveyed. Those respondents had statistically significant different views on pretest Q-1 (The CPR team can deny family in the room during CPR.) p=.007**, than the people that answered “no” on pretest Q-1. With the same question in the posttest, whether people were “present at family death’ or not, made no statistical difference.

People who answered ”yes” on “present at family death” had statistically significant different views on pretest Q - 5 (being with my loved one during CPR would be a spiritual experience for me.) yet, no statistical difference in the posttest survey. Explanation for this difference is difficult, because none of the factual information given to the respondents after the pretest is related to spirituality. The only closely related statements that may be associated, include a sense of closure and FPDR helps to facilitate the grieving process.

In Q -7 (I don’t think the CPR team would want me there) showed significance in both the pretest, p = 0.050* and the posttest, p = 0.004** by those that answered “yes” to having been present at the time of a family or loved one’s death. There was a consistency in the pretest/posttest answers with greater statistical significance in the posttest data. Showing similar significance in both the pretest and posttest also included
Q -10 (I want to be able to touch my loved one during CPR) pretest p = 0.001** and posttest p = 0.003** and Q -16 (The CPR team could perform their duties better if family were not watching them.) pretest p =0.012** and posttest p =0.25*. Both statements

revealed a consistent significance in questions of touch and CPR performance with those who had been present at the time of a family death.

Q -14 (I think most hospitals would allow family members to be present during CPR), pretest p = 0.015 did not show significance in the posttest. People who had been present for family death may have believed that most hospitals did allow presence in the CPR room. These respondents later learned in the factual statement following the pretest that most hospitals do not have policies to support FPDR.

Q -13 (I would rather be in another room with my family members waiting for the CPR team to finish), posttest p = 0.033* shows a significant change following the factual statement. People who had been present at the death of a loved would be more likely to choose to be with the family member or loved rather than to be in another room separated by the CPR team. Having had an experience of being with a loved one at the time of their death does influence the decision of families to participate in FPDR. With this data, research question four can be answered: does life experience, such as being present at a loved ones death, influence the general publics' perception of FPDR? **Yes**

Table 4.7 Present at Family Death – Chi Square[430]

		Pretest		**Posttest**	
		χ^2	**P-value**	χ^2	**P-value**
Q1.	The CPR team can deny family in the room during CPR.	9.78	.044*	6.21	.184
Q2.	I would like to have my loved one with me if CPR was performed on me.	13.26	.010**	15.21	.004**
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	7.60	.107	8.58	.072
Q4.	I think it would reassure my family member if I was at their bedside	7.52	.111	19.24	.001***

[430] Complete "Present at Family Death" data can be found in Appendix; Table 2.16 and 2.17.

Table 4.7 Present at Family Death – Chi Square

	Pretest		Posttest	
	χ^2	P-value	χ^2	P-value
Q5. Being with my loved one during CPR would be a spiritual experience for me.	17.13	.002**	7.85	.09
Q6. I need to stay out of the way so the CPR team can do their job.	6.53	.163	9.25	.055
Q7. I don't think the emergency team would want me there.	9.48	.050*	15.15	.004**
Q8. I have a right to be with my family member in any situation.	8.51	.075	6.05	.196
Q9. I don't know if I could emotionally handle watching CPR.	7.68	.104	8.90	.064
Q10. I want to be able to touch my loved one during the CPR process.	19.55	.001***	16.72	.003**
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	1.92	.751	5.23	.265
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	3.46	.484	7.37	.188
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	4.10	.392	10.49	.033*
Q14. I think most hospitals would allow family members to be present during resuscitation.	12.40	.015*	3.37	.498
Q15. I think it is an invasion of privacy to have family members present.	4.04	.401	6.24	.182
Q16. The CPR team could perform their duties better if family members were not watching them.	12.89	.012*	11.11	.025*
Q17. My family has a high probability of not surviving CPR.	2.07	.732	4.76	.313

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

End-of-Life Wishes Made Known

The majority, sixty percent of all the respondents had made their end-of-life wishes known to someone close to them. This study did not specify whether or not the respondent had made their end-of-life wishes known in the form of an advance directive

document. Including a question regarding a formalized document for end-of-life wishes in the form of the advance directive may have confused the respondents if they were not familiar with the document. The point of the question was to identify formal or informal communication regarding whether or not the respondent had made their wishes known. Sixty percent of respondents who had made their end-of-life wishes known may have had other influences causing them to communicate their needs. Various life experiences could influence the respondent.

In the end-of- life wishes section, there were three pretest questions that were statistically significant: Q - 1 (The CPR team can deny family in the room during CPR.) p = .007**, Q - 9 (I don't know if I could emotionally handle watching CPR.) p = 0.034**, and Q -10 (I want to be able to touch my loved one during CPR.) p = 0.032** Only Q -14 (I think most hospitals would allow family members to be present during CPR) p = 0.044*, was statistically significant in the posttest questions. Those individuals who answered "yes" to making their end-life-wishes known had statistically significant different views on pretest questions regarding denial into the CPR room, emotionally handling FPDR and hospital policy to allow FPDR. Research question number four, does end-of-life planning influence general publics' perception on FPDR? can be answered positively also. Those people who answered "yes" to having made their end-of-life wishes known to someone influences the respondents in four of the survey questions; denying family, emotionally handling, touching, and hospitals allowing FPDR.

Table 4.8 End-of-Life Wishes Made Known: Chi-Square Pre and Post [431]

		Pretest		Posttest	
		χ^2	P-value	χ^2	P-value
Q1.	The CPR team can deny family in the room during CPR.	14.21	.007**	2.98	.561
Q2.	I would like to have my loved one with me if CPR was performed on me.	3.59	.465	2.38	.667
Q3.	I think it would be too traumatic for me to be present with my family	1.64	.802	2.23	.693
Q4.	I think it would reassure my family member if I was at their bedside	9.08	.059	6.18	.191
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	6.68	.154	3.28	.522
Q6.	I need to stay out of the way so the CPR team can do their job.	5.70	.222	6.20	.185
Q7.	I don't think the emergency team would want me there.	5.57	.234	5.32	.256
Q8.	I have a right to be with my family member in any situation.	6.60	.159	3.92	.416
Q9.	I don't know if I could emotionally handle watching CPR.	10.42	.034*	6.20	.185
Q10.	I want to be able to touch my loved one during the CPR process.	10.55	.032*	8.19	.936
Q11.	Because my loved one is not awake, they wouldn't know if I was there anyway.	6.00	.199	3.30	.510
Q12.	I would need to be there to make sure everything was being done to save my loved one's life.	7.71	.103	4.13	.388
Q13.	I would rather be in another room with the other family members waiting for the CPR team to finish.	6.63	.157	2.40	.845
Q14.	I think most hospitals would allow family members to be present during resuscitation.	7.22	.125	9.77	.044*
Q15.	I think it is an invasion of privacy to have family members present.	9.27	.055	4.94	.293
Q16.	The CPR team could perform their duties better if family members were not watching them.	5.00	.287	2.20	.699
Q17.	My family has a high probability of not surviving CPR.	2.2	.697	1.77	.778

Alpha Significance Levels: 0.05, 0.01**, 0.001****

[431] Complete " Wishes Made Known" data can be found in Appendix; Table 2.18 and 2.19.

Discussion Section II – Life Experience

All of the respondents that: 1) experienced family death, 2) were present for a family death, or 3) made their end-of-life wishes known were more likely to want to be present during resuscitation following the factual information that is given. Those respondents who answered "yes" to being present at the time of their loved one's death had a greater possibility of choosing to be present for FPDR than those that answered "no" to having experienced a family death and making their end-of-life wishes known to a loved one. Perhaps the persons who were present for their family member's death found the experience to be an important one, thus finding the possibilities of participation in the FPDR experience to be a definite option.

Section III - Individual Comparisons Using the T-test

The data set in Table 3.0 compared the individual's pre-survey to their post-survey by using the measurement of the t-test. T-tests perform comparisons between the means of the two different groups through the mathematical calculation using the means and the variability, standard deviation, and t-score to indicate the level of significance (indicated by p =) between the two samples.[432] T-test analysis showed statistically significant changes in perceptions regarding FPDR based upon the individual's two test results.

[432] Creswell, 153.

Table 4.0 Individual Pretest/Posttest Comparison Using Paired t-test[433]

	Mean	St. Dev.	t-score	Sig. p=
Q1. The CPR team can deny family in the room during CPR.	-.02273	1.0419	-.434	.664
Q2. I would like to have my loved one with me if CPR was performed on me.	-.0819	1.0085	-1.570	.115
Q3. I think it would be too traumatic for me to be present with my family	.08861	1.1376	1.548	.122
Q4. I think it would reassure my family member if I was at their bedside.	-.01295	1.0823	-.235	.814
Q5. Being with my loved one during CPR would be a spiritual experience for me	-.02065	.78983	-.481	.631
Q6. I need to stay out of the way so the CPR team can do their job.	.27981	.80671	7.032	.000***
Q7. I don't think the emergency team would want me there.	.25505	1.24193	4.087	.000***
Q8. I have a right to be with my family member in any situation.	-.07360	.89224	-1.637	.102
Q9. I don't know if I could emotionally handle watching CPR.	.05637	.91090	1.250	.212
Q10. I want to be able to touch my loved one during the CPR process.	-.25393	.91412	-5.429	.000***
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	.8397	1.00284	1.0660	.098
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	-.15909	.83131	-3.808	.000***
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	.0125	1.01025	.252	.801
Q14. I think most hospitals would allow family members to be present during resuscitation.	-.01256	1.34571	-.186	.852
Q15. I think it is an invasion of privacy to have family members present.	-.19527	1.41957	-2.529	.012*
Q16. The CPR team could perform their duties better if family members were not watching them.	.06329	1.4153	1.102	.271
Q17. My family has a high probability of not surviving CPR.	-.02813	1.28172	-.434	.665

Alpha Significance Levels 0.05, 0.01**, 0.001****

[433] Complete Demographic data for comparison can be found in Appendix; Tables 4.0, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8.

The confidence interval (CI) estimate in this study was indicated by 0.05*, 0.01** or 0.001***.[434] Only five of the questions were identified as statistically significant with the individual pretest/posttest. These data identified the most important changes in the thinking of the individual by way of the educational statement given after the pretest. Question fifteen (I think it is an invasion of a patient's *privacy* to have family members present.) $p = 0.012$* illustrated that respondents significantly believed that their presence is not an invasion of the patient's privacy.[435] Hospitals are required to post and distribute the Patient's Bill of Rights and in these rights the patient is purported to be given privacy.[436] According to this survey, the respondents believed their presence in the resuscitation room did not invade the privacy of their loved one or family member. The respondent may have been more concerned about the ability to be present for their family rather than leaving the CPR room to benefit the resuscitative team. This finding concurred with previous research in the FPDR field in the Duran study.[437]

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[434] Confidence intervals set by researcher for the study, 0.000*** being the highest level of significance to achieve.

[435] http://www.nlm.nih.gov/medlineplus/patientrights.html "As a patient, you have certain rights. Federal law, such as the right to get a copy of your medical records, and the right to keep them private, guarantees some. Many states have additional laws protecting patients, and healthcare facilities often have a patient bill of rights." Retrieved June 30,2013.

[436] Meyers, Eichhhorn, Guzzetta,1998; Mazur, Cox. and Capon; Duran; Eichhorn.

[437] Christine R. Duran, Kathleen S. Oman, Jenni Jordan Abel, Virginia M. Koziel, and Deborah Szymanski, "Attitudes Toward and Beliefs About Family Presence: A Survey of Healthcare Providers, Patients' Families, and Patients, *American Journal of Critical Care* 16, no. 3 (May 2007): 270-79.

Four other questions produced the strictest alpha level of significance, p = 0.000***.[438] The questions with the highest significance were in the areas of touch; present to witness everything was done by the team to save my loved one's life; the need to stay out of the CPR teams way; and the team wanting family out of the way of the resuscitation. Thus, these factual statements had the most significant impact upon the respondents.

The first two questions with statistical significance were Q - 6 (I need to stay out of the way so the CPR team can do their job.) and Q - 7 (I don't think the emergency team would want me there.) Although both comments were closely related, they represented a difference between the respondent's need to stay out of the code team member's work space and the respondent's perception that the code team would prefer that family not be present in the resuscitation room. The respondents' perception was changed as a result of the factual information. Results suggested that these two questions were influenced by the factual statements that were based upon previous research regarding FPDR and the code teams ability to perform their work without being interrupted.[439] Knowledge that families were permitted into the code room and that their presence does not interrupt the code teams ability to perform CPR proved to be beneficial in their ability to make a more autonomous decision as reflected in the questions.

Question Q -10 (I want to be able to touch my loved one during the CPR process.), had a high alpha significance of p = 0.000***. This indicated that the respondents felt very strongly that they should be able to touch their loved one during the

[438] Polit and Beck, 588.

[439] Meyers et al., 1987; Duran; Tomlinson; Meyers, Eichhorn, and Guzzetta.

CPR process. Perhaps most families believed that their loved one was not aware of their presence and could not sense touch during resuscitation prior to the survey. The factual statement clarified to the participants that unconscious patients are able to hear and may perceive family presence.[440]

The statistical significance regarding touch reflected similar findings in the FPDR field. Hanson and Strawser responded to their hospital protocol of FPDR, "Many family members stay only briefly; some come in and out as they feel they are able to handle the situation. The code team makes a place for the visitor at the bedside and encourages them to touch and speak with their loved one."[441] Another large study conveyed the personal comments of many family members who were present for resuscitation. "They (family members present) described the FP (family presence) experience as "powerful," "natural," and the family "right to be with him." despite having emotional responses that depicted as "frightening," "difficult," or "scary, I'd still rather be there.[442] Meyers et al. described the comfort activities that family showed toward their loved one such as; touching, kissing, holding, praying, calming, preventing aloneness, decreasing fear, and giving the patient permission to die.[443]

The last question with high significance was question Q -12 (I would need to be there to make sure everything was being done to save my loved one's life.) p = 0.000***. This indicated the respondent had a stronger need to be in the resuscitation room rather

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[440] Hanson and Strawser (1992), 105.

[441] Hansen and Strawser (1992), 105.

[442] Meyers et al., 2000, 36.

[443] Meyers et al., 2000, 37.

than the previously perceived need to stay out of the CPR room. Factual information was affective to the reader in that their presence could more likely ensure that the code team did not give up too soon on the patient. This outcome was comparable to previous studies and further validated the research question of this study.[444]

Summary of Research Findings

Section I – The analysis looked at the relationship between the demographic information and the seventeen survey questions. Findings were limited in both the pretest and the posttest results. There was not enough statistical significance to draw any conclusions on the demographic data as it relates to the questions. Therefore, we were able to answer research question one: Do different demographic groupings have different perceptions concerning FPDR? **NO** Thus, showing that there are no statistical findings that would support a relationship between demographic information and perceptions concerning FPDR.

Section II – Life experience research findings suggested that those who answered "yes" to any of the life experience questions were more likely to chose to be present for FPDR. The strongest statistical correlation was noted with those answering "yes" to the question indicating past experience of being with a loved one at the time of their death. Perhaps those who have been present at the time of a loved one's death had a positive experience with their presence and with such an exposure would be more comfortable with FPDR. The results of this portion of the survey answers the research questions:

3. Does life experience such as experiencing a loved one's death influence the general publics' perception of FPDR? **YES**

[444] Meyers et al., 2000; Duran and Doyle, 1987.

4. Does life experience such as being present at a loved one's death influence the general publics' perception of FPDR? **YES**
5. Does the relationship between end-of-life planning influence the general publics' perception on FPDR? **YES**

The data from this research showed that those who had experienced the death of a loved one would be more likely to choose to participate in FPDR. The results of the study may indicate the respondent benefitted by the education following the pretest, regarding FPDR, prior to making the decision to be present during resuscitation.

Section III – A comparison of each respondent's pre and posttest answers was analyzed using a paired t-test. Four of the questions showed there was a statistically significant difference after reading the factual information. They are: 1) touch; 2) everything possible done; 3) stay out of the code teams way; and 4) the code team does not want me there. This suggests, that there were positive findings for the final research question: Does factual information regarding resuscitation influence the general public's perception concerning FPDR? **YES**

The final chapter will discuss the implications of this study, the theoretical implications, and recommendations for future studies.

CONCLUSION

Overview of Study

The family-centered healthcare model has become an integral part of medicine today. For example, families are frequently participating in childbirth and presiding over end-of-life experiences through hospice programs. However, the practice of FPDR is limited in many hospitals. Emergency rooms are more likely to have families present during resuscitation, but FPDR on the various units in hospitals is not a common practice. Past habits have dictated that families remain in a waiting room while the code team performs resuscitation on their family member. Then, when the resuscitative efforts are exhausted, the family is allowed to enter the code room to spend time with their loved one. During the last twenty-five years of FPDR research, positive outcomes have been identified from the practice of FPDR. Families have not known that attending their loved one's resuscitation was an option. Practice of FPDR remains predominantly unknown to the lay-public and very few hospitals have policies and procedures in place to allow families in the code room.[445] In the field of FPDR, the majority of research has involved healthcare professionals, not the general public.

Some of the long-standing issues surrounding FPDR have been based upon perception, not fact. Physicians and nurses have been fearful that family members would become too emotional or traumatized, disrupt the resuscitation, or create legal difficulties. Many of these perceptions of the physicians, nurses, or families have already been expansively researched and proven to be misconceptions.

[445] The code room refers to the physical space where the patient is located at the time of their respiratory or cardiac arrest. The emergency code team is then called to attend to the patient in the particular room they arrested in, which is usually in their assigned hospital patient room.

The original FPDR research by Doyle et al.[446] remains the cornerstone for FPDR research. Most of the subsequent studies have included physicians, nurses, and occasionally the patients' families to determine their attitudes regarding FPDR. Regardless of the location of the hospital, staff, and families studied, there is a consistency in the positive outcomes in both the qualitative and quantitative research. Oftentimes, these studies were designed to convince physicians and nurses that including family in the resuscitation room has a positive benefit to the patient, family and the code team. However, the positive outcomes in the research findings have produced very limited change in the hospital environment. To date, most hospitals in the United States do not have FPDR policies in place.

The research is lacking in the study of the general public's knowledge of FPDR. Until the public becomes more aware of their options regarding FPDR, change will not occur in the hospital setting or continue to be very slow in its implementation. If the family is not aware of the concept of FPDR, they will not know enough to ask for the opportunity to be present. Old hospital behaviors and rules need to be adjusted to accommodate the changing needs of the patient and family. It is no longer the choice of only the code team or the physician running the code to make the determination whether or not family should be included in the resuscitation room.

Review of Findings

The purpose of this study was to determine if factual information about FPDR positively influences the perceptions of the lay-public. This original questionnaire was

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[446] Constance J. Doyle, Hank Post, Richard E. Burney, John Maino, Marcie Keefe, and Kenneth J. Rhee, "Family Participation During Resuscitation: An Option," *Annals of Emergency Medicine* 16, no. 6 (June 1987): 673-75.

designed to pretest the public on their knowledge and perceptions of the practice of FPDR, provide factual information retrieved from previous research studies, and give post-tests to the respondents. Although this convenience sample of 443 was significant in size, it is not considered a representative sample. So, the findings were suggestive, not conclusive. However, they point to the direction for future research studies. The strong statistical findings gave us data to suggest the outcomes of the five research questions:

1. Do different demographic groupings have different perceptions concerning FPDR? **No**
2. Does factual information regarding resuscitation influence the general public's perception concerning FPDR? **Yes**
3. Does experiencing a loved one's death influence the general public's perception of FPDR? **Yes**
4. Does being present at a loved one's death influence the general public's perception of FPDR? **Yes**
5. Does end-of-life planning influence the general public's perception of FPDR? **Yes**

The demographic information, question one, was not statistically significant for the study. Each demographic category had two to six different questions that were significant but overall, considered statistically insignificant. Therefore, there were no conclusions to be drawn from the demographic findings. Further research on the topic of FPDR and the influence of demographics should be pursued with a representative sample. Age categories should be expanded for more detailed information so the data can better capture the influence of age on the survey responses. Also, education categories can be divided into more sub-divisions to capture more detailed information.

Research questions two, three, four and five were all shown to have positive findings suggesting the influence of the factual information. While the items have a high probability of occurring at the same time, we do not know with certainty if one item

actually causes another, causality. Statistical data provided support for the idea that factual information influenced the general public's perception on the topic of FPDR. Four of the five research questions were positively affected by the factual information involving resuscitation rather than perception and past practice.

Life experience data suggested positive effects on how a lay person will be influenced by factual information on FPDR. Specific areas of life-experience of the respondents involve those that have: 1. experienced family death, 2. been present at the time of a loved one's death, and/or 3. made their end-of-life wishes known.

Respondents, who answered "yes" to experienced family death, recognized statistical significance in the areas of need to be present for CPR, staying out of the way of the code team, and the team could better perform the code without the family in the room.

People who had been present at a family death would be more likely to choose to be with the family member in the code room during resuscitation, rather than separated in another room. Those respondents who had been present at a family death showed the most statistical significance out of the three areas of life experience. Areas with the most correlation concerned the topics of: having a spiritual experience, ability to touch their loved one, their presence would be reassuring to the patient, the code teams acceptance and their denial in the code room. Perhaps those who had been exposed to an actual death experience of a loved one have already realized the importance of their presence to both the patient and their own personal well-being.

The last category of life experience involved the respondents who had made their end-of-life wishes known to someone else. Those who communicated their end-of life

wishes demonstrated statistical significance in four of the survey questions; denying family in the code room, couldn't emotionally handle FPDR, the need to touch their loved one, and hospitals allowing FPDR. Those respondents who had made their end-of-life wishes known are not necessarily more likely to chose to participate in FPDR.

The third and final section of the research presents the data gathered from a t-test to compare each participant's pretest to their own posttest. Data allowed the researcher to compare the individual's own modifications from the pre-questions to the post-questions. Statistical significance was based upon the factual statement that would more likely have the respondents choose to be present during resuscitation. Questions with the highest significance were in the areas of; touch; present to witness everything was done by the team to save my loved one's life; the need to stay out of the CPR teams way, and the team wanting family out of the way of the resuscitation. These numbers indicated the strongest statistical significance of 0.000***[447] sought after in research. Data showed the individual respondent's change in thinking or perception based upon the factual statement given to them in the survey. Outcomes achieved in the research further substantiate the need for more exposure and education in the topic of FPDR.

Theoretical Implications

Patients and families are more educated consumers than in the past. The practice of medicine is increasingly more complicated and the relationship between the patient and the physician more distant or non-existent. Technological advances and newer ethical

[447] Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

applications provide a foundation for the further discussion of FPDR and its application of some of the ethical principles.

The ethical concept of beneficence, to help or to do no harm with our patients, has provided a level of clarification in the field of FPDR.[448] In the past, the physician or code team manager has primarily decided to leave the family out of the code room, believing that viewing resuscitation would do more emotional harm to the family than to provide any positive outcomes. Because the past twenty-five years of FPDR research has confirmed more positive findings for the family to attend resuscitation, change needs to be implemented in the code room policies. It is our moral and professional obligation in healthcare to assist the patients and their families in decision-making. We must provide accurate and current research information so they may make a more informed autonomous decision.

Paternalism was the dominant and accepted model of the clinical relationship for most of medicine's history.[449] While paternalism has held a prominent role with the physician in an advisory role with the patient and family, the paradigm has shifted. Consumers have become more educated about the rights and responsibilities of patients and/or families. Patient populations have become more transient and medicine more specialized causing the previous physician/patient relationship to become more remote or non-existent. Physicians simply do not know their patients and families as they once did.

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[448] Pellegrino and Thomasma, 9. Beneficence involves roles and relationships, particularly the doctor-patient relationship. Because FPDR involves an unconscious patient and the immediate needs of the family, the concept of beneficence-in-trust becomes more blurred because often times, the physician running the code has no relationship with the patient or the family.

[449] Pellegrino and Thomasma, 13.

It becomes more difficult to advise the patient in personal health issues when there is little or no relationship. Paternalism, as it relates to patient care, was once regarded as a positive influence. But, we must understand that the needs of the patient and their families change. Rights, knowledge, and responsibilities of the patient and families are evolving to address more of their actual needs in family-focused care. The patient, as a consumer, is beginning to demand that more of their personal needs be met in medicine, which includes FPDR.

Patient autonomy should be the focus in healthcare decisions. The fundamental requirement is to respect a particular person's autonomous choices, whatever they may be. "Respect for autonomy is not a mere *ideal* in health care; it is a professional *obligation.* Autonomous choice is a *right*-not a *duty-of* patients."[450] Autonomy bridges the gap between the earlier responsibilities of the physician as a paternalistic decision–maker, to considering a more patient-focused process of including the patient's values and belief system. Decision-making by incorporating the experience of the physician and their knowledge, and the needs and rights of the patient and family should become the standard. "Modern medicine incorporates moments of patient choice as well as moments of necessary, beneficial paternalism."[451]

When given accurate FPDR information, the lay public may become more assertive in their needs, beliefs and concerns. Education is key to a better understanding of the public's need to be with the family members rather than adhering to the previous rules of keeping family away from their loved one at the time of resuscitation. Through

[450] Beauchamp and Childress, 107.

[451] Pellegrino and Thomasma, 14.

more consistent education of the public, using factual information resulting from FPDR research, families and patients would be more prepared for future decisions regarding FPDR throughout the lifespan. Education is empowering and can produce more informed decisions, which better serves the patient and family at the end-of-life. Autonomous decisions in FPDR provide the patient and the family with more positive outcomes regarding their experience of resuscitation.

Future Research

It is incumbent upon today's healthcare institutions to remain diligent in their practices of delivering the finest care to their patients and families. Optimal healthcare includes the participation of patients and their families in many of the most important decisions surrounding their care, including end-of-life.

Evidenced-Based-Practice in healthcare is dependent upon ongoing reputable research. It is not only important to do research but to publish and expose it in several types of venues, such as journals, newspapers, television, and the Internet. Beauchamp and Childress refer to autonomy as requiring from healthcare a fundamental obligation " . . . to ensure that patients have the right to choose, as well as the right to accept or decline information."[452] Even if the patient or family decline FPDR, they can only do so when appropriately informed of the positive and negative outcomes previously researched.

[452] Beauchamp and Childress, 107.

I recommend that FPDR become a part of the Advance Directive document. Discussions surrounding Advanced Directive, as it pertains to resuscitation would be a reasonable time to introduce the FPDR topic to a patient or family member prior to their actual end-of-life experience. Advance Directives are usually completed by a physician, a lawyer or at the request of a patient or family member. The discussion surrounding the wishes of the patient before their death is an important time to begin the FPDR discussion.

Physicians should also discuss FPDR during their conversations surrounding the code status of a loved one.[453] Many institutions have written information regarding the topic of code status and adding the opportunity of FPDR would also be helpful. Often this discussion takes place at the time of the patient's hospitalization or shortly after a patient has gone into respiratory or cardiac arrest. Providing the patient and/or family specific information regarding FPDR would give them an opportunity to discuss and to make a decision whether or not FPDR would be beneficial for them. Information and decision-making is empowering for patient and family.

Additional use of this survey will help increase the reliability of the questionnaire tool. Using more age categories may reveal the trends changing trends of FPDR. In this study, age, gender, marital status, education, ethnicity, and religious affiliation are not significantly related to FPDR perceptions. It will be important to further test this in a randomized representative sample in future research.

[453] Code status is a popular term used in hospitals to describe the extent of the patient's wishes in the event of respiratory or cardiac arrest. There are various levels from "everything being done" to "do not resuscitate" (DNR).

Building on this research, both qualitative and quantitative studies of the perceptions of the lay public could be done. A future qualitative research study could interview people to refine the types of questions in the pre-post test to make sure the research questions are capturing their concerns; compare homogenous groups (e.g., compare under thirty with people over sixty) to further refine differences that may be based on demographics which are not able to be captured in this study. Also, use a smaller sample and have the researcher administer the survey rather than a self-administered questionnaire, so people could add open-ended comments which can then be analyzed for emerging themes.

Using quantitative research, this study could be repeated using a single sample source, such as Survey Monkey; repeat this study design with different questions that are grouped under preset topics (e.g., topics reflecting a belief in the right of autonomy in making healthcare decisions, topics reflecting a deference to doctors/nurses.)

A different design study could be formulated using vignettes for the lay public to view and respond with their perceptions/attitudes of FPDR. Another option could include lay respondents to click on a link to watch a video of CPR being done and then answer questions about their response.

In conclusion, FPDR is an important issue in the delivery of healthcare that is reflective of the ethical principles of paternalism, beneficence and autonomy. Consideration of the needs and desires of the family members of a critically ill patient is an often-stated goal of hospitals. However, FPDR is not uniformly accepted as hospital policy nor is it universally understood by the lay public as their right. Further research in this area is sorely needed to better understand the hospital policies/procedures and how

best to educate healthcare consumers. This research project is a beginning step in the process of knowledge building that can eventually contribute to these changes.

In the end, I ask myself if I would want to witness the resuscitation of any of my family members. Although I cannot answer with certainty at this point, I know, without reservation, that I want to be the one to make the FPDR decision and not the code team, physician, or other healthcare team members. I hope that others will be educated in FPDR and have the opportunity to make an informed autonomous choice regarding FPDR.

Appendix One

Complete Survey Document

Summer 2011

Dear Participant,
You are being asked to participate in a study regarding the public's knowledge of a topic known as "Family Presence During Resuscitation" (FPDR). This is a topic that involves a life-threatening situation of a hospitalized person whose breathing stops or heart stops beating. When this situation occurs the person is given cardiopulmonary resuscitation (CPR) by a group of specially trained doctors, nurses and respiratory therapists. Family members are not usually in the CPR room with the patient and the team of specialists. This survey is designed to ask you questions about what you think about your presence during emergency CPR with a friend or family member who is hospitalized. There is no right or wrong answer. The purpose of this research is to help discover the attitudes of the general public towards an extremely important medical issue and how factual information may influence their attitudes.

As a participant in this survey you are giving permission to the researcher to use the data retrieved from your responses. Every effort will be made to protect your confidentiality. Your name will never be used in the findings and the data will only be presented as a demographic. Participation in the study is voluntary. You can change your mind at any time, and drop out of the study. We expect the survey to take 10-15 minutes. Completion of the survey indicates your consent to participate in this study. **DO NOT** put your name on the survey. It is possible that you will find the topic of this survey upsetting- -should that happen, you are free to discontinue the survey at any time. Along with the survey you will be given a toll-free number of Mental Health America, 800-274-TALK that can assist you with any concerns.

The results of this study will assist healthcare personnel to understand the needs of the general public during emergency resuscitation in the hospital. The direct personal benefits to you are limited.

This study is being conducted by Sarah S. Arnold as part of her dissertation process at Drew University in Madison, New Jersey. If you have any questions you may email her at sarnold@drew.edu. You may also contact Dean William Rogers, Chair of the Institutional Review Board at 973-408-3285, Drew University.

Thank you for your time in completing this survey. Sincerely, Sarah S. Arnold

Please answer the following questions by checking the best response for you. This data will be used to generally describe the participants of this study.

1. Age: ☐ 18-39 ☐ 40-59 ☐ 56-70 ☐ over 70
2. Gender: ☐ male ☐ female
3. Marital Status: ☐ single ☐ married ☐ widowed ☐ div/separated
4. Education: ☐ attending college ☐ attending graduate school
5. Profession: ☐ Not applicable ☐ business ☐ teaching ☐ healthcare ☐ clergy
   ☐ Other _____
6. Ethnicity/Race: *Choose only **one** answer which best describes you:*
   ☐ Caucasian/White ☐ African American/Black ☐ Asian/Pacific Island
   ☐ Hispanic/Latino ☐ multi-racial
7. Religious affiliation: ☐ Christian ☐ Jewish ☐ Muslim ☐ Buddhist
   ☐ Hindu ☐ None/Atheist/Agnostic ☐ Other_____
8. Have you ever had a close friend or immediate family member die? ☐ yes ☐ no
9. Have you ever been present at the time of death of a close friend or immediate family member? ☐ yes ☐ no
10. Have you ever made your end-of-life wishes known to anyone? ☐ yes ☐ no

The following questions are related to this study on hospital patients who require CPR (cardiopulmonary resuscitation) which is given when a patient suddenly stops breathing or their heart stops beating. CPR is performed by a team of specially trained nurses, physicians, and respiratory therapists. CPR usually involves heavy pressing on the chest which can break the patient's ribs, shocking the chest with electricity, placing a breathing tube into the throat, and inserting needles and tubes into the veins of the arms, neck, or groin. Patients are rarely awake during CPR. The procedures usually require that all of the patient's clothes be removed. Sometimes close family members may have the opportunity to be with their hospitalized loved one during the life-saving emergency involving CPR. Please answer the following questions regarding your opinion of family presence during CPR using the following scale. Your answers are not right or wrong. We simply want to know what you think

On the next page you will be asked 15 questions.
Please check **only one** answer.

1-*strongly agree* **(SA)** **2**-*agree* **(A)** **3**-*disagree* **(D)**

4-*strongly disagree* **(SD)** **0**-*not sure* **(NS)**

Please Check the Response That Best Describes Your Opinion

	St.Agree	Agree	Disag	StDis	Not Sure
1. The CPR team can deny family in the room during CPR.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**0** ☐
2. I would like to have my loved one with me if CPR was performed on me.					
3. I think it would be too traumatic for me to be present with my family member during the CPR.					
4. I think it would reassure my family member if I was at their bedside.					
5. Being with my loved one during CPR would be a spiritual experience for me.					
6. I need to stay out of the way so the CPR team can do their job.					
7. I don't think the emergency team would want me there.					
8. I have a right to be with my family member in any situation.					
9. I don't know if I could emotionally handle watching CPR.					
10. I want to be able to touch my loved one during the CPR process.					
11. I would need to be there to make sure everything was being done to save my loved one's life.					
12. I would rather be in another room with the other family members waiting for the CPR team to finish. . . .					
13. I think most hospitals would allow family members to be present during resuscitation.					
14. The CPR team could perform their duties better if family members were not watching them.					
15. 15. Most patients survive CPR in the hospital and return home					

Factual Information

Allowing family to be present during CPR is a controversial subject and is handled differently from hospital to hospital. Only 15 - 18% of in-hospital patients survive the emergency CPR and they are more likely to die than to survive CPR. Some families today believe it is their right to be present during CPR and are exercising that right. Only 5 % of the hospitals across the United States have written policies for family presence during CPR, so it becomes the decision of the individual CPR team to allow family presence during the emergency CPR. The family presence studies conducted over the past 25 years have concluded that there are many positive aspects of family presence during CPR such as:

a) allows opportunity for family member to support and comfort their loved one

b) reduces fear and anxiety that everything possible was done to save their loved one's life

c) provides a sense of closure on their lives together

d) helps facilitate the grieving process the family member

e) encourages more professional behavior of the CPR team

f) reminds the CPR team of the patient's personhood

g) provides an opportunity to educate the family member about the patient's condition

These facts have been given to you to see if this information may influence your decision-making in the future regarding family presence during resuscitation. **The <u>same</u> questions will be asked of you on the next page.**

Appendix Two

Demographic Results – Section I

Table 2.0 Response Rates by Group

Sample Group	Surveys	Surveys Started	% Response Completed
Group H Survey Monkey High School/Less	251	199	79.3%
Group L Luther College College	30	20	66.7%
Group D Drew University College/Graduate	110	81	73.6%
Group C Survey Monkey College	182	140	76.9%

Table 2.1 Demographic Frequency Table

	n	%	Total
Age			433
18 – 39 years	168	38.7%	
40 -59 years	196	45.2%	
60 – 70 years	70	16.1%	
Over 70	0	0	
Gender			434
Female	176	39.7%	
Male	267	60.	
Education			433
High School or Less	199	46.0%	
College/Graduate School	234	54.0%	
Marital Status			443
Single	162	36.6%	
Married	223	49.2%	
Divorced or Separated	49	11.1%	
Widow	9	2.0%	
Ethnicity			439
Caucasian	365	83.1%	
African American	31	7.1%	
Asian/Pacific Island	10	2.3%	
Hispanic/Latino	20	4.6%	
Multi-racial	13	3.0%	
Religious Affiliation			423
Atheist/Agnostic	84	19.9%	
Christian	328	77.4%	
Jewish	9	2.1%	
Hindu	2	0.5%	
Buddhist	0	0	
Muslim	0	0	

Table 2.2 Pre Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q1. The CPR team can deny family in the room during CPR.	18.3% (77)	46.7% (196)	18.3% (77)	10.2% (43)	6.4% (27)	(420)	
18-39 years						(163)	38.8%
40-59 years						(190)	45.2%
60-70 years						(69)	16.4%
Q2. I would like to have my loved one with me if CPR was performed on me.	18.2% (73)	21.9% (112)	29.2% (118)	13.2% (53)	11.2% (45)	(401)	
18-39 years						(151)	37.7%
40-59 years						(182)	45.4%
60-70 years						(68)	17.0%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	15.2% (63)	30.4% (126)	34% (141)	12.8% (53)	7.7% (32)	(415)	
18-39 years						(158)	38.1%
40-59 years						(189)	45.5%
60-70 years						(68)	16.4%
Q4. I think it would reassure my family member if I was at their bedside.	23.6% (97)	40.6% (167)	17.8% (73)	6.8% (28)	11.2% (46)	(411)	
18-39 years						(151)	36.7%
40-59 years						(189)	46.0%
60-70 years						(70)	17.0%

Table 2.2 Pre Survey Results – Age

		Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.6% (37)	17.8% (62)	35.3% (123)	21.8% (76)	14.4% (50)	(348)	
	18-39 years						(123)	35.3%
	40-59 years						(160)	46.0%
	60-70 years						(65)	18.7%
Q6.	I need to stay out of the way so the CPR team can do their job.	54.4% (230)	36.6% (155)	5% (21)	1% (4)	3.1% (13)	(423)	
	18-39 years						(163)	38.5%
	40-59 years						(190)	44.9%
	60-70 years						(70)	16.5%
Q7.	I don't think the emergency team would want me there.	30% (124)	47.6% (197)	9.4% (39)	3.6% (15)	9.4% (39)	(414)	
	18-39 years						(156)	37.7%
	40-59 years						(188)	45.4%
	60-70 years						(70)	16.9%
Q8.	I have a right to be with my family member in any situation.	26% (106)	36.5% (149)	23.5% (96)	5.9% (24)	8.1% (33)	(408)	
	18-39 years						(153)	37.5%
	40-59 years						(186)	45.6%
	60-70 years						(69)	16.9%

Table 2.2 Pre Survey Results – Age

		Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q9.	I don't know if I could emotionally handle watching CPR.	14.1% (59)	31.2% (130)	32.9% (137)	14.4% (60)	7.4% (31)	(417)	
	18-39 years						(161)	38.6%
	40-59 years						(187)	44.8%
	60-70 years						(69)	16.5%
Q10.	I want to be able to touch my loved one during the CPR process.	8.2% (33)	19.7% (79)	41.1% (165)	16.5% (66)	14.5% (58)	(401)	
	18-39 years						(149)	37.2%
	40-59 years						(183)	45.6%
	60-70 years						(69)	17.2%
Q11.	Because my loved one is not awake, they wouldn't know if I was there anyway.	12.8% (52)	29.5% (120)	30.5% (124)	14% (57)	13.3% (54)	(407)	
	18-39 years						(147)	36.1%
	40-59 years						(191)	47.0%
	60-70 years						(69)	17.0%
Q12.	I would need to be there to make sure everything was being done to save my loved one's life.	16.5% (68)	29.9% (123)	32.5% (134)	13.6% (56)	7.5% (31)	(412)	
	18-39 years						(157)	38.1%
	40-59 years						(186)	45.1%
	60-70 years						(69)	16.8%

Table 2.2 Pre Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.3% (50)	34.8% (142)	28.4% (116)	12.5% (51)	12% (49)	(408)	
18-39 years						(153)	37.5%
40-59 years						(186)	45.6%
60-70 years						(69)	16.9%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.6% (27)	19.8% (81)	41.5% (170)	14.1% (58)	18.1% (74)	(410)	
18-39 years						(151)	36.2%
40-59 years						(190)	46.3%
60-70 years						(69)	16.8%
Q15. I think it is an invasion of privacy to have family members present.	5.7% (20)	10.1% (35)	50.3% (175)	20.4% (71)	13.5% (47)	(348)	
18-39 years						(122)	35.1%
40-59 years						(162)	46.6%
60-70 years						(64)	18.4%
Q16. The CPR team could perform their duties better if family members were not watching them.	20.2% (84)	36.5% (152)	21.2% (88)	8.7% (36)	13.5% (56)	(416)	
18-39 years						(159)	38.2%
40-59 years						(189)	45.4%
60-70 years						(68)	16.4%

Table 2.2 Pre Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q17. My family has a high probability of not surviving CPR.	8.4% (34)	26.2% (106)	20.5% (83)	6.9% (28)	37.9% (153)	(404)	
18-39 years						(155)	38.4%
40-59 years						(183)	45.3%
60-70 years						(66)	16.3%

Table 2.2– Post Survey Results - Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.	16% (64)	48.1% (193)	21.7% (87)	8.7% (35)	5.5% (22)	(401)	
18 – 39 years						(155)	38.7%
40 - 59 years						(181)	45.1%
60 -70 years						(65)	16.2%
Q2. I would like to have my loved one with me if CPR was performed on me.	19.7% (77)	34.6% (135)	23.8% (93)	10% (39)	11.8% (46)	(390)	
18-39 years						(144)	36.8%
40-59 years						(182)	46.7%
60-70 years						(64)	6.4%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	13.4% (54)	32.3% (130)	29.8% (120)	13.9% (56)	10.7% (43)	(403)	
18-39 years						(158)	39.2%
40-59 years						(181)	44.9%
60-70 years						(64)	15.9%
Q4. I think it would reassure my family member if I was at their bedside.	22.2% (89)	42.6% (171)	18.2% (73)	5.2% (21)	11.7% (47)	(401)	
18-39 years						(155)	38.7%
40-59 years						(183)	45.6%
60-70 years						(63)	15.7%

Table 2.2 Post Survey Results – Age

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.6% (44)	17.8% (63)	35.3% (113)	21.8% (62)	14.4% (57)	(339)	
	18-39 years						(124)	36.6%
	40-59 years						(155)	45.7%
	60-70 years						(60)	7.7%
Q6.	I need to stay out of the way so the CPR team can do their job.	37% (151)	48% (196)	6.9% (28)	3.7% (15)	4.4% (18)	(408)	
	18-39 years						(160)	39.2%
	40-59 years						(184)	45.1%
	60-70 years						(64)	15.7%
Q7.	I don't think the emergency team would want me there.	20.3% (81)	46.7% (186)	15.8% (63)	4% (16)	13.1% (52)	(398)	
	18-39 years						(152)	38.2%
	40-59 years						(183)	46.0%
	60-70 years						(63)	5.8%
Q8.	I have a right to be with my family member in any situation.	27.8% (111)	37.5% (150)	24.1% (99)	4% (16)	6% (24)	(400)	
	18-39-years						(157)	39.2%
	40-59 years						(180)	44.9%
	60-70 years						(64)	16.0%

Table 2.2 Post Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.	13.5% (55)	30.2% (123)	31.9% (130)	15.7% (64)	8.6% (35)	(407)	
18-39 years						(161)	38.6%
40-59 years						(187)	44.8%
60-70 years						(69)	16.5%
Q10. I want to be able to touch my loved one during the CPR process.	8.2% (56)	19.7% (99)	41.1% (152)	16.5% (45)	14.5% (45)	(397)	
18-39 years						(148)	38.2%
40-59 years						(187)	47.1%
60-70 years						(62)	15.6%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	9.8% (39)	28% (111)	33.8% (134)	15.1% (60)	13.1% (52)	(396)	
18-39 years						(150)	37.9%
40-59 years						(182)	47.2%
60-70 years						(64)	16.1%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17.3% (69)	35.9% (143)	32.2% (128)	9.0% (36)	5.5% (22)	(398)	
18-39 years						(156)	39.2%
40-59 years						(178)	44.7%
60-70 years						(64)	16.0%

Table 2.2 Post Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.5% (41)	33.9% (133)	32.1% (126)	12.8% (50)	10.7% (42)	(392)	
18-39 years						(147)	37.5%
40-59 years						(181)	46.2%
60-70 years						(64)	16.3%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.4% (22)	13.3% (54)	51.1% (207)	21.2% (86)	8.9% (36)	(405)	
18-39 years						(158)	39.0%
40-59 years						(182)	45.0%
60-70 years						(65)	16.0.%
Q15. I think it is an invasion of privacy to have family members present.	7.4% (25)	23.7% (80)	40.2% (136)	13% (44)	15.7% (53)	(338)	
18-39 years						(124)	36.7%
40-59 years						(154)	45.6%
60-70 years						(60)	17.8%
Q16. The CPR team could perform their duties better if family members were not watching them.	20.2% (68)	36.5% (127)	21.2% (120)	8.7% (39)	13.5% (47)	(401)	
18-39 years						(153)	38.2%
40-59 years						(184)	45.9%
60-70 years						(64)	16.0%

Table 2.2 Post Survey Results – Age

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q17. My family has a high probability of not surviving CPR.	8.4% (20)	26.2% (51)	20.5% (163)	6.9% (114)	37.9% (60)	(408)	
18-39- years						(159)	38.9%
40-59 years						(184)	45.1%
60-70 years						(65)	15.9%

Table 2.4 Pre Survey Results - Gender

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	18.2% (78)	46.7% (200)	18.7% (80)	10% (43)	6.3% (27)	(428)	
	Female						(173)	40.4%
	Male						(255)	9.6%
Q2.	I would like to have my loved one with me if CPR was performed on me.	18.1% (74)	27.6% (113)	29.6% (121)	13.4% (55)	11.2% (46)	(409)	
	Female						(164)	40.1%
	Male						(245)	59.9%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	15.4% (65)	30.3% (128)	34.2% (145)	12.5% (53)	7.6% (32)	(423)	
	Female						(172)	40.7%
	Male						(251)	59.3%
Q4.	I think it would reassure my family member if I was at their bedside.	23.2% (97)	40.2% (168)	18.1% (76)	7.2% (30)	11.2% (47)	(418)	
	Female						(168))	40.2%
	Male						(250)	59.8%
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.5% (37)	17.8% (63)	35.6% (126)	22% (78)	14.1% (50)	(354)	
	Female						(148)	41.8%
	Male						(206)	58.2%
Q6.	I need to stay out of the way so the CPR team can do their job.	53.9% (233)	37% (160)	4.9% (21)	1.2% (5)	3% (13)	(432)	
	Female						(171)	39.6%
	Male						(261)	60.4%

Table 2.4 Pre Survey Results - Gender

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7. I don't think the emergency team would want me there.	29.9% (126)	47.3% (199)	9.5% (40)	3.8% (16)	9.5% (40)	(421)	
Female						(167)	39.7%
Male						(254)	60.3%
Q8. I have a right to be with my family member in any situation.	25.7% (107)	36.8% (153)	23.3% (97)	6% (25)	8.2% (34)	(416)	
Female						(165)	39.7%
Male						(251)	60.3%
Q9. I don't know if I could emotionally handle watching CPR.	14.4% (61)	31.3% (133)	33.2% (140)	14.1% (60)	7.3% (31)	(425)	
Female						(170)	40.0%
Male						(255)	60.0%
Q10. I want to be able to touch my loved one during the CPR process.	8.1% (33)	19.4% (79)	41.4% (169)	16.9% (69)	14.2% (58)	(408)	
Female						(164)	41.2%
Male						(244)	59.8%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	13% (54)	29.5% (122)	30.4% (126)	14% (58)	13% (54)	(414)	
Female						(165)	39.9%
Male						(249)	60.1%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.2% (68)	29.8% (125)	33.1% (139)	13.6% (57)	7.4% (31)	(420)	
Female						(167)	39.8%
Male						(253)	60.2%

Table 2.4 Pre Survey Results - Gender

	Strongly	Agree	Disagree	Strongly	Don't	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.3% (51)	35.2% (146)	28.4% (118)	12.3% (51)	11.8% (49)	(415)	
Female						(168)	40.5%
Male						(247)	59.5%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.5% (27)	19.9% (83)	41.7% (174)	13.9% (58)	18% (75)	(417)	
Female						(168)	40.3%
Male						(249)	59.7%
Q15. I think it is an invasion of privacy to have family members present.	5.7% (20)	9.9% (35)	50.7% (179)	20.1% (71)	13.6% (48)	(353)	
Female						(149)	42.2%
Male						(204)	57.8%
Q16. The CPR team could perform their duties better if family members were not watching them.	20.1% (85)	36.6% (155)	21% (89)	8.7% (37)	13.5% (57)	(423)	
Female						(171)	40.4%
Male						(252)	59.6%
Q17. My family has a high probability of not surviving CPR.	8.8% (36)	26% (107)	20.7% (85)	6.8% (28)	37.7% (155)	(411)	
Female						(167)	40.6%
Male						(244)	59.4%

Table 2.5 Post Survey Results - Gender

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	15.7% (64)	48.5% (198)	21.3% (87)	8.6% (35)	5.9% (24)	(408)	
	Female						(166)	40.7%
	Male						(242)	59.3%
Q2.	I would like to have my loved one with me if CPR was performed on me.	19.4% (77)	34.3% (136)	24.7% (98)	10.1% (40)	11.6% (46)	(397)	
	Female						(161)	40.6%
	Male						(236)	59.4%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	15.4% (55)	30.3% (132)	34.2% (124)	12.5% (56)	7.6% (43)	(410)	
	Female						(160)	39.0%
	Male						(250)	61.0%
Q4.	I think it would reassure my family member if I was at their bedside.	21.9% (89)	42.3% (172)	18.4% (75)	5.4% (22)	12% (49)	(407)	
	Female						(163))	40.0%
	Male						(244)	60.0%
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	12.8% (44)	18.6% (64)	33.7% (116)	18.3% (63)	16.6% (57)	(344)	
	Female						(148)	43.0%
	Male						(196)	57.0%
Q6.	I need to stay out of the way so the CPR team can do their job.	36.8% (153)	48.1% (200)	7.0% (29)	3.8% (16)	4.3% (18)	(416)	
	Female						(166)	39.9%
	Male						(250)	60.1%

Table 2.5 Post Survey Results - Gender

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7. I don't think the emergency team would want me there.	20.3% (82)	46.8% (189)	15.8% (64)	4% (16)	13.1% (53)	(40)	
Female						(160)	39.6%
Male						(244)	60.4%
Q8. I have a right to be with my family member in any situation.	27.2% (111)	37.7% (154)	24.8% (101)	4% (16)	6.4% (26)	(40)	
Female						(165)	40.4%
Male						(243)	59.6%
Q9. I don't know if I could emotionally handle watching CPR.	13.5% (56)	30.7% (127)	31.9% (132)	15.5% (64)	8.5% (35)	(414)	
Female						(164)	39.6%
Male						(250)	60.4%
Q10. I want to be able to touch my loved one during the CPR process.	14.2% (56)	22.6% (89)	39.7% (156)	11.7% (46)	11.7% (46)	(393)	
Female						(162)	41.2%
Male						(231)	58.8%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	10% (40)	28.4% (114)	33.3% (134)	14.9% (60)	13.4% (54)	(402)	
Female						(163)	40.5%
Male						(239)	59.5%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17% (69)	35.8% (145)	32.6% (132)	9.1% (37)	5.4% (22)	(405)	
Female						(165)	40.7%
Male						(240)	59.3%

Table 2.5 Post Survey Results - Gender

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.6% (42)	34.3% (136)	31.7% (126)	12.6% (50)	10.8% (43)	(397)	
Female						(160)	40.3%
Male						(237)	59.7%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.6% (23)	13.3% (55)	51% (210)	20.9% (86)	9.2% (38)	(412)	
Female						(167)	40.5%
Male						(245)	59.5%
Q15. I think it is an invasion of privacy to have family members present.	7.3% (25)	23.6% (81)	40.5% (139)	13.1% (45)	15.5% (53)	(343)	
Female						(147)	42.9%
Male						(196)	57.1%
Q16. The CPR team could perform their duties better if family members were not watching them.	16.9% (69)	31.4% (128)	30% (122)	9.6% (39)	12% (49)	(407)	
Female						(164)	40.3%
Male						(243)	59.7%
Q17. My family has a high probability of not surviving CPR.	4.8% (20)	12.8% (53)	39.8% (165)	28% (116)	14.7% (61)	(415)	
Female						(166)	40.0%
Male						(249)	60.0%

Table 2.6 Pre Survey Results – Marital Status

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	18.2% (78)	46.7% (200)	18.7% (80)	10% (43)	6.3% (27)	(428)	
	Single						(154)	36.0%
	Married						(218)	50.9%
	Divorced/Separated						(48)	11.2%
	Widow						(8)	1.9%
Q2.	I would like to have my loved one with me if CPR was performed on me.	18% (74)	27.6% (113)	29.6% (121)	13.4% (55)	11.2% (46)	(409)	
	Single						(145)	35.4%
	Married						(208)	50.9%
	Divorced/Separated						(47)	11.5%
	Widow						(9)	2.2%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	15.4% (65)	30.3% (128)	34.3% (145)	12.5% (53)	7.6% (32)	(423)	
	Single						(154)	36.4%
	Married						(212)	50.1%
	Divorced/Separated						(48)	11.3%
	Widow						(9)	2.1%
Q4.	I think it would reassure my family member if I was at their bedside.	23.2% (97)	40.2% (168)	18.2% (76)	7.2% (30)	11.2% (47)	(418)	
	Single						(147)	35.2%
	Married						(215)	51.4%
	Divorced/Separated						(48)	11.5%
	Widow						(8)	1.9%

Table 2.6 Pre Survey Results – Marital Status

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.5% (37)	17.8% (63)	35.6% (126)	22.0% (78)	14.1% (50)	(354)	
	Single						(121)	34.2%
	Married						(180)	50.8%
	Divorced/Separated						(45)	12.7%
	Widow						(8)	2.3%
Q6.	I need to stay out of the way so the CPR team can do their job.	53.9% (233)	37% (160)	4.9% (21)	1.2% (5)	3.0% (13)	(432)	
	Single						(158)	36.6%
	Married						(217)	50.2%
	Divorced/Separated						(48)	11.1%
	Widow						(9)	2.1%
Q7.	I don't think the emergency team would want me there.	29.9% (126)	47.3% (199)	9.5% (40)	3.8% (16)	9.5% (40)	(421)	
	Single						(150)	35.6%
	Married						(213)	50.6%
	Divorced/Separated						(49)	11.6%
	Widow						(9)	2.1%
Q8.	I have a right to be with my family member in any situation.	25.7% (107)	36.8% (153)	23.3% (97)	6.0% (25)	8.2% (34)	(416)	
	Single						(147)	35.3%
	Married						(213)	51.2%
	Divorced/Separated						(47)	11.3%
	Widow						(9)	2.2%

Table 2.6 Pre Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.	14.4% (61)	31.3% (133)	32.9% (140)	14.1% (60)	7.3% (31)	(425)	
Single						(154)	36.2%
Married						(215)	50.6%
Divorced/Separated						(48)	11.3%
Widow						(8)	1.9%
Q10. I want to be able to touch my loved one during the CPR process.	8.1% (33)	19.4% (79)	41.4% (160)	16.9% (69)	14.2% (58)	(408)	
Single						(144)	35.3%
Married						(209)	51.2%
Divorced/Separated						(46)	11.3%
Widow						(9)	2.2%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	13% (54)	29.5% (122)	30.4% (126)	14% (58)	13.0% (54)	(414)	
Single						(143)	34.5%
Married						(215)	51.9%
Divorced/Separated						(47)	11.4%
Widow						(9)	2.2%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.2% (68)	29.8% (125)	33.1% (139)	13.6% (57)	7.4% (31)	(420)	
Single						(151)	36.0%
Married						(211)	50.2%
Divorced/Separated						(49)	11.7%
Widow						(9)	2.1%

Table 2.6 Pre Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.3% (51)	35.2% (146)	28.4% (118)	12.3% (51)	11.8% (49)	(415)	
Single						(147)	35.4%
Married						(211)	50.8%
Divorced/Separated						(49)	11.8%
Widow						(8)	1.9%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.5% (27)	19.9% (83)	41.7% (174)	13.9% (58)	18% (75)	(417)	
Single						(146)	35.0%
Married						(215)	51.6%
Divorced/Separated						(48)	11.5%
Widow						(8)	1.9%
Q15. I think it is an invasion of privacy to have family members present.	5.7% (20)	9.9% (35)	50.7% (179)	20.1% (71)	13.6% (48)	(353)	
Single						(121)	34.3%
Married						(180)	51.0%
Divorced/Separated						(45)	12.7%
Widow						(7)	2.0%

Table 2.6 Pre Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	20.1% (85)	36.6% (155)	21% (89)	8.7% (37)	13.5% (57)	(423)	
Single						(154)	36.4%
Married						(214)	50.6%
Divorced/Separated						(48)	11.3%
Widow						(7)	1.7%
Q17. My family has a high probability of not surviving CPR.	8.8% (36)	26.0% (107)	20.7% (85)	6.8% (28)	37.7% (155)	(411)	
Single						(149)	36.3%
Married						(207)	50.4%
Divorced/Separated						(47)	11.4%
Widow						(8)	1.9%

Table 2.7 Post Survey Results – Marital Status

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	15.7% (64)	48.5% (198)	21.3% (87)	8.6% (35)	5.9% (24)	(408)	
	Single						(151)	37.0%
	Married						(204)	50.0%
	Divorced/Separated						(46)	11.3%
	Widow						(7)	1.7%
Q2.	I would like to have my loved one with me if CPR was performed on me.	19.4% (77)	34.3% (136)	24.7% (98)	10.1% (40)	11.6% (46)	(397)	
	Single						(141)	35.5%
	Married						(203)	51.1%
	Divorced/Separated						(45)	11.3%
	Widow						(8)	2.0%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	13.4% (55)	32.2% (132)	30.2% (124)	13.7% (56)	10.5% (43)	(410)	
	Single						(149)	36.3%
	Married						(207)	50.5%
	Divorced/Separated						(46)	11.2%
	Widow						(8)	2.0%
Q4.	I think it would reassure my family member if I was at their bedside.	21.9% (89)	42.3% (172)	18.4% (75)	5.4% (2)	12.0% (49)	(407)	
	Single						(146)	35.9%
	Married						(206)	50.6%
	Divorced/Separated						(47)	11.5%
	Widow						(8)	2.0%

Table 2.7 Post Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.	12.8% (44)	18.6% (64)	33.7% (116)	18.3% (63)	16.6% (57)	(344)	
Single						(120)	34.9%
Married						(174)	50.6%
Divorced/Separated						(43)	12.5%
Widow						(7)	2.0%
Q6. I need to stay out of the way so the CPR team can do their job.	36.8% (153)	48.1% (200)	7.0% (29)	3.8% (16)	4.3% (18)	(416)	
Single						(153)	36.8%
Married						(208)	50.0%
Divorced/Separated						(47)	11.3%
Widow						(8)	1.9%
Q7. I don't think the emergency team would want me there.	20.3% (82)	46.8% (189)	15.8% (64)	4.0% (16)	13.1% (53)	(404)	
Single						(143)	35.4%
Married						(206)	51.0%
Divorced/Separated						(47)	11.6%
Widow						(8)	2.0%
Q8. I have a right to be with my family member in any situation.	27.2% (111)	37.7% (154)	24.8% (101)	3.9% (16)	6.4% (26)	(408)	
Single						(148)	36.3%
Married						(207)	50.7%
Divorced/Separated						(45)	11.0%
Widow						(8)	2.0%

Table 2.7 Post Survey Results – Marital Status

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9.	I don't know if I could emotionally handle watching CPR.	13.5% (56)	30.7% (127)	31.9% (132)	15.5% (64)	8.5% (35)	(414)	
	Single						(150)	36.2%
	Married						(210)	50.7%
	Divorced/Separated						(46)	11.1%
	Widow						(8)	1.9%
Q10.	I want to be able to touch my loved one during the CPR process.	14.2% (56)	22.6% (89)	39.7% (156)	11.7% (46)	11.7% (46)	(393)	
	Single						(140)	35.6%
	Married						(200)	50.9%
	Divorced/Separated						(45)	11.5%
	Widow						(8)	2.0%
Q11.	Because my loved one is not awake, they wouldn't know if I was there anyway.	10.0% (40)	28.4% (114)	33.3% (134)	14.9% (60)	13.4% (54)	(402)	
	Single						(144)	34.8%
	Married						(205)	51.0%
	Divorced/Separated						(45)	11.2%
	Widow						(8)	2.0%
Q12.	I would need to be there to make sure everything was being done to save my loved one's life.	17.0% (69)	38.8% (145)	32.6% (132)	9.1% (37)	5.4% (22)	(405)	
	Single						(148)	36.5%
	Married						(202)	49.9%
	Divorced/Separated						(47)	11.6%
	Widow						(8)	2.0%

Table 2.7 Post Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.6% (42)	34.3% (136)	31.7% (126)	12.6% (50)	10.8% (43)	(397)	
Single						(139)	35.0%
Married						(204)	51.4%
Divorced/Separated						(47)	11.8%
Widow						(7)	1.8%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.6% (23)	13.3% (55)	51.0% (210)	20.9% (86)	9.7% (38)	(412)	
Single						(149)	36.2%
Married						(208)	50.5%
Divorced/Separated						(47)	11.4%
Widow						(8)	1.9%
Q15. I think it is an invasion of privacy to have family members present.	7.3% (25)	23.6% (81)	40.5% (139)	13.1% (45)	15.5% (53)	(343)	
Single						(120)	35.0%
Married						(173)	50.4%
Divorced/Separated						(43)	12.5%
Widow						(7)	2.0%

Table 2.7 Post Survey Results – Marital Status

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	17.0% (69)	31.4% (128)	30.0% (122)	9.6% (39)	12.0% (49)	(407)	
Single						(145)	35.6%
Married						(208)	51.1%
Divorced/Separated						(46)	11.3%
Widow						(8)	2.0%
Q17. My family has a high probability of not surviving CPR.	4.8% (20)	12.8% (53)	39.8% (165)	28.0% (116)	14.7% (61)	(415)	
Single						(151)	36.4%
Married						(210)	50.6%
Divorced/Separated						(46)	11.1%
Widow						(8)	1.9%

Table 2.8 Pre Survey Results - Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.	18.2% (78)	46.7% (200)	18.7% (80)	10.1% (43)	6.3% (27)	(428)	
High School or less						(198)	46.3%
College/Graduate School						(230)	53.7%
Q2. I would like to have my loved one with me if CPR was performed on me.	18.1% (74)	27.6% (113)	29.6% (121)	13.5% (55)	11.3% (46)	(409)	
High School or less						(195)	47.7%
College/Graduate School						(214)	52.3%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	15.4% (65)	30.3% (128)	34.3% (145)	12.5% (53)	7.6% (32)	(423)	
High School or less						(197)	46.5%
College/Graduate School						(226)	53.4%
Q4. I think it would reassure my family member if I was at their bedside.	23.2% (97)	40.2% (168)	18.2% (76)	7.2% (30)	11.2% (47)	(418)	
High School or less						(195)	46.7%
College/Graduate School						(223)	53.3%
Q5. Being with my loved one during CPR would be a spiritual experience for me.	10.5% (37)	17.8% (63)	35.6% (126)	22.0% (78)	14.1% (50)	(354)	
High School or less						(195)	55.1%
College/Graduate School						(159)	44.9%

Table 2.8 Pre Survey Results - Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
Q6. I need to stay out of the way so the CPR team can do their job.	53.9% (233)	37.0% (160)	4.9% (21)	1.2% (5)	3.0% (13)	(432)
High School or less						(198) 45.8%
College/Graduate School						(233) 53.9%
Q7. I don't think the emergency team would want me there.	29.9% (126)	47.3% (199)	9.5% (40)	3.8% (16)	9.5% (40)	(421)
High School or less						(197) 46.8%
College/Graduate School						(224) 53.2%
Q8. I have a right to be with my family member in any situation.	25.7% (107)	36.8% (153)	23.3% (97)	6.0% (25)	8.2% (34)	(416)
High School or less						(197) 47.4%
College/Graduate School						(219) 52.6%
Q9. I don't know if I could emotionally handle watching CPR.	14.4% (61)	31.3% (133)	32.9% (140)	14.1% (60)	7.3% (31)	(425)
High School or less						(196) 46.1%
College/Graduate School						(229) 53.9%
Q10. I want to be able to touch my loved one during the CPR process.	8.1% (33)	19.4% (79)	41.4% (169)	16.9% (69)	14.2% (58)	(408)
High School or less						(197) 48.3%
College/Graduate School						(211) 51.7%

Table 2.8 Pre Survey Results – Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway. 1	3.0% (54)	29.5% (122)	30.4% (126)	14.% (58)	13.0% (54)	(414)
High School or less						(196) 47.3%
College/Graduate School						(218) 52.7%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.2% (68)	29.8% (125)	33.1% (139)	13.6% (57)	7.4% (31)	(420)
High School or less						(196) 46.7%
College/Graduate School						(224) 53.3%
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.3% (51)	35.2% (146)	28.4% (118)	12.3% (51)	11.8% (49)	(415)
High School or less						(195) 47.0%
College/Graduate School						(220) 43.0%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.5% (27)	19.9% (83)	41.7% (174)	13.9% (58)	18.0% (75)	(417)
High School or less						(194) 46.5%
College/Graduate School						(223) 53.5%
Q15. I think it is an invasion of privacy to have family members present.	5.7% (20)	9.9% (35)	50.7% (179)	20.1% (71)	13.6% (48)	(353)
High School or less						(194) 55.0%
College/Graduate School						(159) 45.0%

Table 2.8 Pre Survey Results – Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
Q16. The CPR team could perform their duties better if family members were not watching them.	20.1% (85)	36.6% (155)	44.7% (189)	8.7%1 (37)	3.5% (57)	(423)
High School or less						(197) 46.6%
College/Graduate School						(226) 53.4%
Q17. My family has a high probability of not surviving CPR.	8.8% (36)	26.0% (107)	20.7% (85)	6.8% (28)	37.7% (155)	(411)
High School or less						(197) 47.9%
College/Graduate School						(214) 52.1%

Table 2.9 Post Survey Results – Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.	15.7% (64)	48.5% (198)	21.3% (87)	8.6% (35)	8.6% (24)	(408)	
High School or less						(196)	48.0%
College/Graduate School						(212)	52.0%
Q2. I would like to have my loved one with me if CPR was performed on me.	11.6% (46)	10.1% (40)	24.7% (98)	24.3% (136)	34.3% (77)	(397)	
High School or less						(195)	49.1%
College/Graduate School						(202)	50.9%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	13.4% (55)	32.2% (132)	30.2% (124)	13.7% (56)	10.5% (43)	(410)	
High School or less						(193)	47.1%
College/Graduate School						(217)	53.0%
Q4. I think it would reassure my family member if I was at their bedside.	21.7% (89)	42.3% (172)	18.4% (75)	5.4% (22)	12% (49)	(407)	
High School or less						(196)	48.2%
College/Graduate School						(211)	51.8%
Q5. Being with my loved one during CPR would be a spiritual experience for me.	12.8% (44)	18.6% (64)	33.7% (116)	18.3% (63)	16.6% (57)	(344)	
High School or less						(196)	56.0%
College/Graduate School						(148)	43.0%

Table 2.9 Post Survey Results – Education

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
Q6.	I need to stay out of the way so the CPR team can do their job.	36.8% (153)	48.1% (200)	7% (29)	3.8% (16)	4.3% (18)	(416)
	High School or less						(197) 47.4%
	College/Graduate School						(219) 52.6%
Q7.	I don't think the emergency team would want me there.	20.3% (82)	46.8% (189)	15.8% (64)	4% (16)	13.1% (53)	(404)
	High School or less						(193) 47.8%
	College/Graduate School						(211) 52.2%
Q8.	I have a right to be with my family member in any situation.	27.2% (111)	37.7% (154)	24.8% (101)	4% (16)	6.4% (26)	(408)
	High School or less						(194) 47.6%
	College/Graduate School						(214) 59.1%
Q9.	I don't know if I could emotionally handle watching CPR.	13.5% (56)	30.7% (127)	31.9% (132)	15.5% (64)	8.5% (35)	(414
	High School or less						(196) 47.3%
	College/Graduate School						(218) 52.7%
Q10.	I want to be able to touch my loved one during the CPR process.	14.2% (56)	22.6% (89)	39.7% (156)	11.7% (46)	11.7% (46)	(393)
	High School or less						(194) 49.4%
	College/Graduate School						(199) 50.6%

Table 2.9 Post Survey Results – Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	10% (40)	28.4% (114)	33.3% (134)	14.9% (60)	13.4% (54)	(402)
High School or less						(195) 48.5%
College/Graduate School						(207) 51.5%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17% (69)	35.8% (145)	32.6% (132)	9.1% (37)	5.4% (22)	(405)
High School or less						(196) 48.4%
College/Graduate School						(209) 51.0%
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.6% (42)	34.3% (136)	31.7% (126)	12.6% (50)	10.8% (43)	(397)
High School or less						(194) 48.9%
College/Graduate School						(203) 51.2%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.6% (23)	13.3% (55)	51% (210)	20.9% (86)	9.2% (38)	(412)
High School or less						(195) 47.3%
College/Graduate School						(217) 52.7%
Q15. I think it is an invasion of privacy to have family members present.	7.3% (25)	23.6% (81)	40.5% (139)	13.1% (45)	15.5% (53)	(343)
High School or less						(196) 57.1%
College/Graduate School						(147) 42.9%

Table 2.9 Post Survey Results – Education

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	16.9% (69)	31.4% (128)	30% (122)	9.6% (39)	12% (49)	(407)	
High School or less						(196)	48.2%
College/Graduate School						(211)	51.8%
Q17. My family has a high probability of not surviving CPR.	4.8% (20)	12.8% (53)	39.8% (165)	28% (116)	14.7% (61)	(415)	
High School or less						(193)	46.5%
College/Graduate School						(222)	53.5%

Table 2.10 Pre Survey Results – Ethnicity

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	6.3% (27)	10.1% (43)	18.4% (78)	46.7% (198)	18.4% (78)	(424)	
	Caucasian						(354)	83.5%
	African American						(28)	6.6%
	Asian/Pacific Island						(9)	2.1%
	Hispanic/Latino						(20)	4.7%
	Multi-racial						(13)	3.1%
Q2.	I would like to have my loved one with me if CPR was performed on me.	11.3% (46)	13.3% (54)	29.6% (120)	27.6% (112)	18.2% (74)	(406)	
	Caucasian						(336)	82.8%
	African American						(29)	7.1%
	Asian/Pacific Island						(9)	2.2%
	Hispanic/Latino						(20)	4.9%
	Multi-racial						(12)	3.0%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	7.6% (32)	12.6% (53)	34.6% (145)	29.9% (125)	15.3% (64)	(419)	
	Caucasian						(346)	82.5%
	African American						(31)	7.4%
	Asian/Pacific Island						(10)	2.4%
	Hispanic/Latino						(20)	4.8%
	Multi-racial						(12)	2.9%

Table 2.10 Pre Survey Results – Ethnicity

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q4.	I think it would reassure my family member if I was at their bedside.	21.9% (47)	42.3% (29)	18.4% (76)	5.4% (165)	12.0% (97)	(414)	
	Caucasian						(342)	82.6%
	African American						(30)	7.0%
	Asian/Pacific Island						(10)	2.4%
	Hispanic/Latino						(19)	4.6%
	Multi-racial						(13)	3.1%
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.5% (37)	17.9% (63)	35.5% (125)	21.9% (77)	14.2% (50)	(352)	
	Caucasian						(293)	83.2%
	African American						(22)	6.3%
	Asian/Pacific Island						(8)	2.3%
	Hispanic/Latino						(19)	5.4%
	Multi-racial						(10)	2.8%
Q6.	I need to stay out of the way so the CPR team can do their job.	54.0% (231)	36.9% (158)	4.9% (21)	1.2% (5)	3.0% (13)	(428)	
	Caucasian						(356)	83.2%
	African American						(29)	6.8%
	Asian/Pacific Island						(10)	2.3%
	Hispanic/Latino						(20)	4.7%
	Multi-racial						(13)	3.0%

Table 2.10 Pre Survey Results – Ethnicity

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7.	I don't think the emergency team would want me there.	29.7% (124)	47.2% (197)	9.6% (40)	3.8% (16)	9.6% (40)	(417)	
	Caucasian						(348)	83.5%
	African American						(28)	6.7%
	Asian/Pacific Island						(9)	2.2%
	Hispanic/Latino						(19)	4.6%
	Multi-racial						(13)	3.1%
Q8.	I have a right to be with my family member in any situation.	25.9% (107)	36.6% (151)	22.8% (96)	6.1% (25)	8.2% (34)	(413)	
	Caucasian						(343)	83.1%
	African American						(27)	6.5%
	Asian/Pacific Island						(10)	2.4%
	Hispanic/Latino						(20)	4.8%
	Multi-racial						(13)	3.1%
Q9.	I don't know if I could emotionally handle watching CPR.	14.0% (59)	31.4% (132)	33.0% (139)	14.3% (60)	7.4% (31)	(421)	
	Caucasian						(349)	82.9%
	African American						(29)	6.9%
	Asian/Pacific Island						(10)	2.4%
	Hispanic/Latino						(20)	4.8%
	Multi-racial						(13)	3.1%

Table 2.10 Pre Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q10. I want to be able to touch my loved one during the CPR process.	8.2% (33)	19.3% (78)	41.3% (167)	16.8% (68)	14.4% (58)	(404)	
Caucasian						(336)	83.2%
African American						(27)	6.7%
Asian/Pacific Island						(8)	2.0%
Hispanic/Latino						(20)	5.0%
Multi-racial						(13)	3.2%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	13.1% (54)	29.4% (121)	30.2% (124)	14.1% (58)	13.1% (54)	(411)	
Caucasian						(342)	83.2%
African American						(27)	6.6%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(20)	4.9%
Multi-racial						(12)	2.9%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.3% (68)	29.6% (123)	33.2% (138)	13.5% (56)	7.5% (31)	(416)	
Caucasian						(345)	82.9%
African American						(29)	7.0%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(20)	4.8%
Multi-racial						(12)	2.9%

Table 2.10 Pre Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.4% (51)	34.8% (143)	28.5% (117)	12.4% (51)	9.7% (40)	(411)	
Caucasian						(342)	83.2%
African American						(27)	6.6%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(19)	4.6%
Multi-racial						(13)	3.2%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.5% (27)	20.0% (83)	41.2% (171)	14.0% (58)	18.1% (75)	(414)	
Caucasian						(344)	83.1%
African American						(30)	7.2%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(18)	4.3%
Multi-racial						(12)	2.9%
Q15. I think it is an invasion of privacy to have family members present.	5.7% (20)	9.7% (34)	50.7% (178)	20.2% (71)	13.7% (48)	(351)	
Caucasian						(291)	82.9%
African American						(24)	6.8%
Asian/Pacific Island						(8)	2.3%
Hispanic/Latino						(19)	5.4%
Multi-racial						(9)	2.6%

Table 2.10 Pre Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	20.0% (84)	36.8% (154)	20.8% (87)	8.8% (37)	13.6% (57)	(419)	
Caucasian						(349)	83.2%
African American						(27)	6.4%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(20)	4.8%
Multi-racial						(13)	3.1%
Q17. My family has a high probability of not surviving CPR.	8.8% (36)	25.9% (106)	20.8% (85)	6.6% (27)	37.9% (155)	(409)	
Caucasian						(339)	82.9%
African American						(28)	6.8%
Asian/Pacific Island						(9)	2.2%
Hispanic/Latino						(20)	4.9%
Multi-racial						(13)	3.2%

Table 2.11 Post Survey - Ethnicity

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	15.6% (63)	48.4% (196)	21.5% (87)	8.6% (35)	5.9% (24)	(405)	
	Caucasian						(334)	82.4%
	African American						(29)	7.2%
	Asian/Pacific Island						(10)	2.5%
	Hispanic/Latino						(19)	4.7%
	Multi-racial						(13)	3.2%
Q2.	I would like to have my loved one with me if CPR was performed on me.	19.4% (77)	34.3% (136)	24.7% (98)	9.8% (39)	11.6% (46)	(396)	
	Caucasian						(329)	83.0%
	African American						(27)	6.8%
	Asian/Pacific Island						(10)	2.5%
	Hispanic/Latino						(18)	4.5%
	Multi-racial						(12)	3.0%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	13.5% (55)	31.7% (129)	30.5% (124)	13.8% (56)	10.6% (43)	(407)	
	Caucasian						(338)	83.0%
	African American						(29)	7.1%
	Asian/Pacific Island						(10)	2.5%
	Hispanic/Latino						(17)	4.2%
	Multi-racial						(13)	3.2%

Table 2.11 Post Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q4. I think it would reassure my family member if I was at their bedside.	21.7% (88)	42.5% (172)	18.5% (75)	5.2% (21)	12.1% (49)	(405)	
Caucasian						(337)	83.2%
African American						(29)	7.2%
Asian/Pacific Island						(9)	2.2%
Hispanic/Latino						(18)	4.4%
Multi-racial						(12)	3.0%
Q5. Being with my loved one during CPR would be a spiritual experience for me.	12.8% (44)	18.7% (64)	33.8% (116)	18.7% (63)	16.6% (57)	(343)	
Caucasian						(283)	82.5%
African American						(24)	7.0%
Asian/Pacific Island						(8)	2.3%
Hispanic/Latino						(18)	5.2%
Multi-racial						(10)	2.9%
Q6. I need to stay out of the way so the CPR team can do their job.	37.0% (153)	47.7% (197)	7.0% (29)	3.9% (16)	4.4% (18)	(413)	
Caucasian						(342)	82.8%
African American						(29)	7.0%
Asian/Pacific Island						(10)	2.4%
Hispanic/Latino						(19)	4.6%
Multi-racial						(13)	3.1%

Table 2.11 Post Survey Results – Ethnicity

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7.	I don't think the emergency team would want me there.	20.1% (81)	46.8% (188)	15.9% (64)	4.0% (16)	13.2% (53)	(402)	
	Caucasian						(335)	83.3%
	African American						(29)	7.2%
	Asian/Pacific Island						(9)	2.2%
	Hispanic/Latino						(17)	4.2%
	Multi-racial						(12)	3.0%
Q8.	I have a right to be with my family member in any situation.	27.4% (111)	37.5% (152)	24.9% (101)	3.7% (15)	6.4% (26)	(405)	
	Caucasian						(334)	82.5%
	African American						(29)	7.2%
	Asian/Pacific Island						(10)	2.5%
	Hispanic/Latino						(19)	4.7%
	Multi-racial						(13)	3.2%
Q9.	I don't know if I could emotionally handle watching CPR.	13.3% (55)	30.6% (126)	32.0% (132)	15.3% (64)	8.5% (35)	(412)	
	Caucasian						(340)	82.5%
	African American						(30)	7.3%
	Asian/Pacific Island						(10)	2.4%
	Hispanic/Latino						(19)	4.6%
	Multi-racial						(13)	3.2%

Table 2.11 Post Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q10. I want to be able to touch my loved one during the CPR process.	14.3% (56)	22.8% (89)	39.6% (155)	11.5% (45)	11.8% (46)	(391)	
Caucasian						(324)	82.9%
African American						(27)	6.9%
Asian/Pacific Island						(8)	2.0%
Hispanic/Latino						(19)	4.9%
Multi-racial						(13)	3.3%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	10.0% (40)	28.5% (114)	33.0% (132)	15.0% (60)	13.5% (54)	(400)	
Caucasian						(333)	83.5%
African American						(26)	6.5%
Asian/Pacific Island						(10)	2.5%
Hispanic/Latino						(19)	4.8%
Multi-racial						(12)	3.0%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17.2% (69)	35.8% (144)	32.6% (131)	9.0% (36)	5.5% (22)	(402)	
Caucasian						(332)	82.6%
African American						(29)	7.2%
Asian/Pacific Island						(10)	2.5%
Hispanic/Latino						(19)	4.7%
Multi-racial						(12)	3.0%

Table 2.11 Post Survey Results – Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.6% (42)	33.9% (134)	31.9% (126)	12.7% (50)	10.9% (43)	(395)	
Caucasian						(326)	82.5%
African American						(29)	7.3%
Asian/Pacific Island						(10)	2.5%
Hispanic/Latino						(17)	4.3%
Multi-racial						(13)	3.3%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.6% (23)	13.2% (54)	51.0% (209)	21.0% (86)	9.3% (38)	(410)	
Caucasian						(341)	83.1%
African American						(30)	7.3%
Asian/Pacific Island						(9)	2.2%
Hispanic/Latino						(18)	4.4%
Multi-racial						(12)	2.9%
Q15. I think it is an invasion of privacy to have family members present.	7.3% (25)	23.7% (81)	40.4% (138)	13.2% (45)	15.5% (53)	(342)	
Caucasian						(282)	82.5%
African American						(24)	7.0%
Asian/Pacific Island						(8)	2.3%
Hispanic/Latino						(18)	5.3%
Multi-racial						(10)	2.9%

Table 2.11 Post Survey Results - Ethnicity

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	17.0% (69)	31.4% (127)	30.1% (122)	9.6% (39)	12.1% (49)	(405)	
Caucasian						(335)	82.7%
African American						(28)	6.9%
Asian/Pacific Island						(10)	2.5%
Hispanic/Latino						(19)	4.7%
Multi-racial						(13)	3.2%
Q17. My family has a high probability of not surviving CPR.	4.8% (20)	12.8% (53)	40.0% (165)	27.6% (114)	14.8% (61)	(413)	
Caucasian						(345)	83.5%
African American						(28)	6.8%
Asian/Pacific Island						(9)	2.2%
Hispanic/Latino						(19)	4.6%
Multi-racial						(12)	2.9%

Table 2.12 Pre Survey – Religious Affiliation
(No Buddhist or Muslim)

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	18.6% (76)	46.1% (188)	18.9% (77)	10.3% (42)	6.1% (25)	(408)	
	Atheist/Agnostic						(81)	19.9%
	Christian						(317)	77.7%
	Jewish						(8)	2.0%
	Hindu						(2)	0.5%
Q2.	I would like to have my loved one with me if CPR was performed on me.	18.5% (72)	26.9% (105)	29.5% (115)	14.1% (55)	11.0% (43)	(390)	
	Atheist/Agnostic						(74)	19.0%
	Christian						(308)	79.0%
	Jewish						(6)	1.5%
	Hindu						(2)	0.5%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	17.8% (72)	26.0% (105)	28.5% (115)	13.6% (55)	10.6% (43)	(404)	
	Atheist/Agnostic						(78)	19.3%
	Christian						(315)	78.0%
	Jewish						(9)	2.2%
	Hindu						(2)	0.5%

Table 2.12 Pre Survey – Religious Affiliation

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q4.	I think it would reassure my family member if I was at their bedside.	23.1% (92)	39.4% (157)	18.6% (74)	7.3% (29)	11.6% (46)	(398)	
	Atheist/Agnostic						(78)	19.6%
	Christian						(310)	77.9%
	Jewish						(8)	2.0%
	Hindu						(2)	0.5%
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	10.7% (36)	17.8% (60)	35.3% (119)	22.3% (75)	13.9% (47)	(337)	
	Atheist/Agnostic						(63)	18.7%
	Christian						(271)	80.4%
	Jewish						(2)	0.6%
	Hindu						(1)	0.3%
Q6.	I need to stay out of the way so the CPR team can do their job.	52.9% (219)	38.2% (158)	4.8% (20)	1.2% (5)	29.7% (123)	(414)	
	Atheist/Agnostic						(83)	20.0%
	Christian						(320)	77.3%
	Jewish						(9)	2.2%
	Hindu						(2)	0.5%

Table 2.12 Pre Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7. I don't think the emergency team would want me there.	30.1% (121)	47.3% (190)	9.2% (37)	3.7% (15)	9.7% (39)	(402)	
Atheist/Agnostic						(80)	19.9%
Christian						(311)	77.4%
Jewish						(9)	2.2%
Hindu						(2)	0.5%
Q8. I have a right to be with my family member in any situation.	26.3% (104)	36.1% (143)	22.7% (90)	6.3% (25)	8.6% (34)	(396)	
Atheist/Agnostic						(76)	19.2%
Christian						(310)	78.3%
Jewish						(6)	1.5%
Hindu						2)	0.5%
Q9. I don't know if I could emotionally handle watching CPR.	14.3% (58)	31.3% (127)	33.0% (134)	14.5% (59)	7.0% (29)	(406)	
Atheist/Agnostic						(79)	19.5%
Christian						(317)	8.1%
Jewish						(8)	2.0%
Hindu						(2)	0.5%

Table 2.12 Pre Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q10. I want to be able to touch my loved one during the CPR process.	13.9% (54)	17.2% (67)	42.9% (167)	19.3% (75)	8.0% (31)	(389)	
Atheist/Agnostic						(75)	19.3%
Christian						(306)	78.7%
Jewish						(7)	1.8%
Hindu						(1)	0.3%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	13.4% (53)	29.1% (115)	30.9% (122)	13.9% (55)	12.7% (50)	(395)	
Atheist/Agnostic						(77)	19.5%
Christian						(308)	78.0%
Jewish						(8)	2.0%
Hindu						(2)	0.5%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.3% (65)	31.0% (174)	33.3% (133)	13.5% (54)	7.8% (31)	(400)	
Atheist/Agnostic						(77)	19.3%
Christian						(312)	78.0%
Jewish						(9)	2.3%
Hindu						(2)	0.5%

Table 2.12 Pre Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.4% (49)	35.4% (140)	28.0% (111)	12.4% (49)	11.9% (47)	(396)	
Atheist/Agnostic						(77)	19.4%
Christian						(309)	78.0%
Jewish						(8)	2.0%
Hindu						(2)	0.5%
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.5% (26)	19.3% (77)	42.0% (168)	14.0% (56)	18.3% (73)	(400)	
Atheist/Agnostic						(78)	19.5%
Christian						(313)	78.3%
Jewish						(7)	1.8%
Hindu						(2)	0.5%
Q15. I think it is an invasion of privacy to have family members present.	5.9% (20)	9.5% (32)	51.6% (174)	19.6% (66)	13.4% (45)	(337)	
Atheist/Agnostic						(63)	18.7%
Christian						(270)	80.1%
Jewish						(3)	0.9%
Hindu						(1)	0.3%

Table 2.12 Pre Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	20.3% (82)	36.4% (147)	20.8% (84)	8.9% (36)	13.6% (55)	(404)	
Atheist/Agnostic						(80)	19.8%
Christian						(314)	77.7%
Jewish						(8)	2.0%
Hindu						(2)	0.5%
Q17. My family has a high probability of not surviving CPR.	9.3% (36)	25.5% (100)	20.2% (79)	7.1% (28)	38.0% (149)	(392)	
Atheist/Agnostic						(77)	19.6%
Christian						(306)	78.1%
Jewish						(7)	1.9%
Hindu						(2)	0.5%

Table 2.13 Post Survey – Religious Affiliation
(No Buddhist or Muslim Responses)

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.	15.1% (59)	49.5% (193)	21.5% (84)	8.2% (32)	5.6% (22)	(390)	
	Atheist/Agnostic						(78)	20.0%
	Christian						(301)	77.2%
	Jewish						(9)	2.3%
	Hindu						(2)	0.5%
Q2.	I would like to have my loved one with me if CPR was performed on me.	19.7% (75)	33.7% (128)	25.0% (95)	10.3% (39)	11.3% (43)	(380)	
	Atheist/Agnostic						(73)	19.2%
	Christian						(300)	78.9%
	Jewish						(5)	1.3%
	Hindu						(2)	0.5%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.	13.6% (53)	32.2% (126)	29.7% (116)	14.1% (55)	10.5% (41)	(391)	
	Atheist/Agnostic						(78)	19.9%
	Christian						(303)	77.5%
	Jewish						(8)	2.0%
	Hindu						(2)	0.5%

Table 2.13 Post Survey – Religious Affiliation

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q4.	I think it would reassure my family member if I was at their bedside.	21.9% (85)	41.9% (163)	18.8% (73)	5.7% (22)	11.8% (46)	(389)	
	Atheist/Agnostic						(77)	19.8%
	Christian						(301)	77.4%
	Jewish						(9)	2.3%
	Hindu						(2)	0.5%
Q5.	Being with my loved one during CPR would be a spiritual experience for me.	13.1% (43)	18.6% (61)	33.5% (110)	18.6% (61)	13.1% (43)	(328)	
	Atheist/Agnostic						(62)	18.9%
	Christian						(262)	79.9%
	Jewish						(3)	0.9%
	Hindu						(1)	0.3%
Q6.	I need to stay out of the way so the CPR team can do their job.	36.3% (144)	48.4% (192)	7.1% (28)	3.8% (15)	4.5% (18)	(397)	
	Atheist/Agnostic						(80)	20.2%
	Christian						(307)	77.3%
	Jewish						(8)	2.0%
	Hindu						(2)	0.5%

Table 2.13 Post Survey – Religious Affiliation

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q7.	I don't think the emergency team would want me there.	20.5% (79)	47.7% (184)	15.3% (59)	3.9% (15)	12.7% (49)	(386)	
	Atheist/Agnostic						(77)	20.0%
	Christian						(299)	77.5%
	Jewish						(8)	2.1%
	Hindu						(2)	0.5%
Q8.	I have a right to be with my family member in any situation.	26.3% (107)	37.3% (145)	24.4% (95)	4.1% (16)	6.7% (26)	(389)	
	Atheist/Agnostic						(78)	20.1%
	Christian						(301)	77.4%
	Jewish						(8)	2.1%
	Hindu						(2)	0.5%
Q9.	I don't know if I could emotionally handle watching CPR.	13.6% (54)	30.6% (121)	31.8% (126)	15.7% (62)	8.3% (33)	(396)	
	Atheist/Agnostic						(78)	19.7%
	Christian						(308)	77.8%
	Jewish						(8)	2.1%
	Hindu						(2)	0.5%

Table 2.13 Post Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q10. I want to be able to touch my loved one during the CPR process.	14.1% (53)	23.2% (87)	39.5% (148)	12.0% (45)	11.2% (42)	(375)	
Atheist/Agnostic						(71)	18.9%
Christian						(297)	79.2%
Jewish						(6)	1.6%
Hindu						(1)	0.3%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	10.2% (39)	28.1% (108)	32.8% (126)	14.8% (57)	14.1% (54)	(384)	
Atheist/Agnostic						(76)	19.8%
Christian						(298)	77.6%
Jewish						(8)	2.1%
Hindu						(2)	0.5%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.6% (64)	35.8% (138)	32.9% (127)	9.3% (36)	5.4% (21)	(386)	
Atheist/Agnostic						(76)	19.7%
Christian						(299)	77.5%
Jewish						(9)	2.3%
Hindu						(2)	0.5%

Table 2.13 Post Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	10.8% (41)	34.3% (130)	30.9% (117)	12.9% (49)	11.1% (42)	(379)	
Atheist/Agnostic						(69)	18.2%
Christian						(300)	79.2%
Jewish						(8)	2.1%
Hindu						(2)	0.5%
Q14. I think most hospitals would allow family members to be present during resuscitation.	5.6% (22)	13.4% (53)	51.7% (204)	20.3% (80)	9.1% (36)	(395)	
Atheist/Agnostic						(78)	19.7%
Christian						(307)	77.7%
Jewish						(8)	2.0%
Hindu						(2)	0.5%
Q15. I think it is an invasion of privacy to have family members present.	7.6% (25)	22.9% (75)	40.5% (133)	13.1% (43)	15.9% (52)	(328)	
Atheist/Agnostic						(62)	18.9%
Christian						(262)	79.9%
Jewish						(3)	0.9%
Hindu						(1)	0.3%

Table 2.13 Post Survey – Religious Affiliation

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q16. The CPR team could perform their duties better if family members were not watching them.	17.3% (67)	31.2% (121)	29.9% (116)	9.5% (37)	12.1% (47)	(388)	
Atheist/Agnostic						(76)	19.6%
Christian						(302)	77.8%
Jewish						(8)	2.1%
Hindu						(2)	0.5%
Q17. My family has a high probability of not surviving CPR.	5.0% (20)	12.6% (50)	39/3% (156)	28.5% (113)	38.0% (58)	(397)	
Atheist/Agnostic						(79)	19.9%
Christian						(308)	77.6%
Jewish						(8)	2.0%
Hindu						(2)	0.5%

Appendix Three

Life Experience – Section II

Table 3.0 Experience Family Death – Pre-Survey

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1.	The CPR team can deny family in the room during CPR.						(427)	
	Yes	(73)	(169)	(68)	(38)	(23)	(371)	86.9%
	No	(5)	(31)	(12)	(4)	(4)	(56)	13.1%
Q2.	I would like to have my loved one with me if CPR was performed on me.						(408)	
	Yes	(64)	(95)	(105)	(52)	(39)	(356)	87.3%
	No	(9)	(18)	(15)	(3)	(7)	(52)	12.7%
Q3.	I think it would be too traumatic for me to be present with my family member during the CPR.						(422)	
	Yes	(62)	(112)	(127)	(41)	(26)	(368)	87.2%
	No	(3)	(16)	(18)	(11)	(6)	(54)	12.8%
Q4.	I think it would reassure my family member if I was at their bedside.						(417)	
	Yes	(86)	(146)	(67)	(27)	(38)	(364)	87.3%
	No	(10)	(22)	(9)	(3)	(9)	(53)	12.7%

Table 3.0 Experience Family Death – Pre-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(353)	
Yes	(33)	(57)	(112)	(66)	(42)	(310)	87.8%
No	(3)	(6)	(14)	(12)	(8)	(43)	12.2%
Q6. I need to stay out of the way so the CPR team can do their job.						(431)	
Yes	(206)	(140)	(17)	(4)	(9)	(376)	87.2%
No	(26)	(20)	(4)	(1)	(4)	(55)	12.8%
Q7. I don't think the emergency team would want me there.						(420)	
Yes	(117)	(168)	(35)	(12)	(33)	(365)	86.9%
No	(9)	(30)	(5)	(4)	(7)	(55)	13.1%
Q8. I have a right to be with my family member in any situation.						(415)	
Yes	(95)	(135)	(820	(23)	(27)	(362)	87.2%
No	(11)	(18)	(15)	(2)	(7)	(53)	12.8%
Q9. I don't know if I could emotionally handle watching CPR.						(424)	
Yes	(58)	(109)	(121)	(52)	(28)	(368)	86.8%
No	(3)	(24)	(19)	(7)	(3)	(56)	13.2%

Table 3.0 Experience Family Death – Pre-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q10. I want to be able to touch my loved one during the CPR process.						(407)	
Yes	(29)	(72)	(143)	(63)	(48)	(357)	87.7%
No	(3)	(7)	(26)	(4)	(10)	(50)	12.3%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(413)	
Yes	(48)	(103)	(113)	(52)	(45)	(361)	87.4%
No	(6)	(19)	(13)	(5)	(9)	(52)	12.6%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(419)	
Yes	(60)	(111)	(124)	(48)	(24)	(361)	87.4%
No	(7)	(14)	(15)	(9)	(7)	(52)	12.4%
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(414)	
Yes	(49)	(125)	(104)	(43)	(39)	(360)	87.0%
No	(2)	(21)	(14)	(7)	(10)	(54)	13.0%

Table 3.0 Experience Family Death – Pre-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q14. I think most hospitals would allow family members to be present during resuscitation.						(416)	
Yes	(21)	(71)	(155)	(55)	(62)	(364)	87.5%
No	(5)	(12)	(19)	(3)	(13)	(52)	12.5%
Q15. I think it is an invasion of privacy to have family members present.						(352)	
Yes	(19)	(31)	(155)	(62)	(42)	(309)	87.8%
No	(1)	(4)	(24)	(8)	(6)	(43)	12.2%
Q16. The CPR team could perform their duties better if family members were not watching them.						(422)	
Yes	(78)	(128)	(84)	(31)	(45)	(366)	86.7%
No	(7)	(27)	(5)	(5)	(12)	(56)	13.3%
Q17. My family has a high probability of not surviving CPR.						(410)	
Yes	(32)	(97)	(73)	(22)	(135)	(359)	87.6%
No	(4)	(10)	(12)	(5)	(20)	(51)	12.4%

Table 3.1 Experience Family Death – Post Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.						(407)	
Yes	(59)	(167)	(77)	(28)	(22)	(353)	86.7%
No	(5)	(31)	(10)	(6)	(2)	(56)	13.8%
Q2. I would like to have my loved one with me if CPR was performed on me.						(396)	
Yes	(69)	(111)	(88)	(39)	(37)	(344)	86.9%
No	(7)	(25)	(10)	(1)	(9)	(52)	13.1%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.						(409)	
Yes	(52)	(115)	(108)	(47)	(3)	(354)	86.6%
No	(3)	(17)	(16)	(8)	(11)	(55)	13.5%
Q4. I think it would reassure my family member if I was at their bedside.						(406)	
Yes	(80)	(143)	(69)	(20)	(38)	(350)	86.2%
No	(8)	(29)	(6)	(2)	(11)	(56)	13.8%
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(343)	
Yes	(38)	(58)	(103)	(54)	(46)	(299)	87.2%
No	(5)	(6)	(13)	(9)	(11)	(44)	12.8%

Table 3.1 Experience Family Death – Post-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q6. I need to stay out of the way so the CPR team can do their job.						(415)	
Yes	(138)	(175)	(23)	(10)	(13)	(359)	86.5%
No	(14)	(25)	(6)	(6)	(5)	(56)	13.5%
Q7. I don't think the emergency team would want me there.						(403)	
Yes	(76)	(162)	(54)	(12)	(43)	(347)	86.1%
No	(5)	(27)	(10)	(4)	(10)	(56)	13.9%
Q8. I have a right to be with my family member in any situation.						(407)	
Yes	(97)	(133)	(87)	(14)	(21)	(352)	86.5%
No	(13)	(21)	(14)	(2)	(5)	(55)	12.8%
Q9. I don't know if I could emotionally handle watching CPR.						(413)	
Yes	(52)	(105)	(115)	(57)	(29)	(358)	86.7%
No	(4)	(22)	(17)	(6)	(6)	(55)	13.3%
Q10. I want to be able to touch my loved one during the CPR process.						(392)	
Yes	(50)	(75)	(138)	(41)	(38)	(342)	87.5%
No	(5)	(14)	(18)	(5)	(8)	(50)	12.8%

Table 3.1 Experience Family Death – Post-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(401)	
Yes	(34)	(97)	(121)	(53)	(43)	(348)	86.8%
No	(6)	(17)	(13)	(6)	(11)	(53)	13.2%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(404)	
Yes	(58)	(126)	(117)	(33)	(17)	(351)	86.9%
No	(10)	(19)	(15)	(4)	(5)	(53)	13.1%
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(396)	
Yes	(40)	(118)	(110)	(42)	(35)	(345)	87.1%
No	(2)	(18)	(16)	(7)	(8)	(51)	12.9%
Q14. I think most hospitals would allow family members to be present during resuscitation.						(411)	
Yes	(20)	(51)	(178)	(75)	(32)	(356)	86.6%
No	(3)	(4)	(32)	(10)	(6)	(55)	13.4%

Table 3.1 Experience Family Death – Post-Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q15. I think it is an invasion of privacy to have family members present.						(342)	
Yes	(21)	(64)	(125)	(40)	(48)	(298)	87.1%
No	(4)	(17)	(14)	(4)	(5)	(44)	12.9%
Q16. The CPR team could perform their duties better if family members were not watching them.						(406)	
Yes	(63)	(110)	(106)	(32)	(41)	(352)	86.7%
No	(6)	(18)	(16)	(6)	(18	(54)	13.3%
Q17. My family has a high probability of not surviving CPR.						(414)	
Yes	(17)	(49)	(139)	(101)	(53)	(359)	86.7%
No	(3)	(4)	(26)	(14)	(8)	(55)	13.3%

Table 3.2 Present for Family Death - Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.						(426)	
Yes	(44)	(77)	(27)	(19)	(11)	(178)	41.8%
No	(34)	(121)	(53)	(24)	(16)	(248)	58.2%
Q2. I would like to have my loved one with me if CPR was performed on me.						(407)	
Yes	(37)	(35)	(56)	(31)	(17)	(176)	43.2%
No	(36)	(77)	(65)	(24)	(29)	(231)	56.8%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.						(421)	
Yes	(33)	(42)	(60)	(26)	(14)	(175)	41.6%
No	(3)2	(86)	(83)	(27)	(18)	(246)	58.4%
Q4. I think it would reassure my family member if I was at their bedside.						(416)	
Yes	(46)	(62)	(37)	(16)	(16)	(177)	42.5%
No	(49)	(106)	(39)	(14)	(31)	(239)	57.5%

Table 3.2 Present for Family Death - Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(352)	
Yes	(25)	(21)	(56)	(40)	(15)	(157)	44.6%
No	(12)	(42)	(69)	(37)	(35)	(195)	55.4%
Q6. I need to stay out of the way so the CPR team can do their job.						(430)	
Yes	(103)	(57)	(13)	(2)	(6)	(181)	42.1%
No	(129)	(102)	(8)	(3)	(7)	(249)	57.9%
Q7. I don't think the emergency team would want me there.						(419)	
Yes	(64)	(69)	(18)	(9)	(16)	(176)	42.0%
No	(62)	(128)	(22)	(7)	(24)	(243)	58.0%
Q8. I have a right to be with my family member in any situation.						(414)	
Yes	(57)	(57)	(36)	(13)	(15)	(178)	43.0%
No	(50)	(95)	(60)	(12)	(19)	(236)	57.0%

Table 3.2 Present For Family Death – Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.						(423)	
Yes	(29)	(49)	(58)	(33)	(12)	(179)	42.3%
No	(31)	(86)	(81)	(27)	(19)	(244)	57.7%
Q10. I want to be able to touch my loved one during the CPR process.						(406)	
Yes	(20)	(40)	(66)	(39)	(15)	(180)	44.3%
No	(13)	(39)	(101)	(30)	(43)	(226)	55.7%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(412)	
Yes	(27)	(52)	(50)	(26)	(24)	(179)	43.4%
No	(26)	(70)	(75)	(32)	(30)	(233)	56.6%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(418)	
Yes	(29)	(55)	(54)	(30)	(12)	(180)	43.1%
No	(38)	(69)	(85)	(27)	(19)	(238)	56.9%

Table 3.2 Present for Family Death - Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(413)	
Yes	(25)	(58)	(47)	(26)	(18)	(174)	42.1%
No	(26)	(87)	(71)	(24)	(34)	(239)	57.9%
Q14. I think most hospitals would allow family members to be present during resuscitation.						(415)	
Yes	(14)	(27)	(68)	(34)	(35)	(178)	42.9%
No	(13)	(56)	(105)	(23)	(40)	(237)	57.1%
Q15. I think it is an invasion of privacy to have family members present.						(351)	
Yes	(12)	(12)	(78)	(31)	(24)	(157)	44.7%
No	(8)	(23)	(100)	(39)	(24)	(194)	55.3%
Q16. The CPR team could perform their duties better if family members were not watching them.						(421)	
Yes	(49)	(58)	(34)	(16)	(18)	(175)	41.6%
No	(36)	(96)	(55)	(20)	(39)	(246)	58.4%

Table 3.2 Present for Family Death - Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q17. My family has a high probability of not surviving CPR.						(409)	
Yes	(18)	(48)	(33)	(12)	(62)	(179)	42.3%
No	(18)	(58)	(52)	(15)	(93)	(236)	57.7%

Table 3.3 Present for Family Death - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.						(407)	
Yes	(35)	(75)	(33)	(15)	(11)	(169)	41.5%
No	(29)	(122)	(54)	(20)	(13)	(238)	58.5%
Q2. I would like to have my loved one with me if CPR was performed on me.						(396)	
Yes	(34)	(48)	(43)	(27)	(15)	(167)	42.2%
No	(42)	(88)	(55)	(13)	(31)	(229)	57.8%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.						(409)	
Yes	(30)	(50)	(53)	(26)	(12)	(171)	41.8%
No	(25)	(82)	(70)	(30)	(31)	(238)	58.2%
Q4. I think it would reassure my family member if I was at their bedside.						(406)	
Yes	(45)	(54)	(38)	(14)	(16)	(167)	41.1%
No	(43)	(118)	(37)	(8)	(33)	(239)	58.9%

Table 3.3 Present for Family Death - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(343)	
Yes	(23)	(27)	(47)	(34)	(18)	(149)	43.4%
No	(21)	(37)	(68)	(29)	(39)	(194)	56.6%
Q6. I need to stay out of the way so the CPR team can do their job.						(415)	
Yes	(73)	(69)	(16)	(5)	(8)	(171)	41.2%
No	(80)	(130)	(13)	(11)	(10)	(244)	58.8%
Q7. I don't think the emergency team would want me there.						(403)	
Yes	(48)	(76)	(22)	(6)	(15)	(167)	41.4%
No	(34)	(112)	(42)	(10)	(38)	(236)	58.6%
Q8. I have a right to be with my family member in any situation.						(407)	
Yes	(49)	(59)	(40)	(11)	(10)	(169)	41.5%
No	(62)	(95)	(60)	(5)	(16)	(238)	58.5%

Table 3.3 Present for Family Death - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.						(413)	
Yes	(30)	(48)	(55)	(31)	(9)	(173)	41.9%
No	(26)	(79)	(76)	(33)	(26)	(240)	58.1%
Q10. I want to be able to touch my loved one during the CPR process.						(392)	
Yes	(29)	(36)	(56)	(30)	(15)	(166)	42.3%
No	(27)	(53)	(99)	(16)	(31)	(226)	57.7%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(401)	
Yes	(22)	(41)	(60)	(26)	(21)	(170)	42.4%
No	(18)	(73)	(73)	(34)	(33)	(231)	57.6%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(404)	
Yes	(32)	(57)	(50)	(22)	(7)	(168)	41.6%
No	(37)	(87)	(82)	(15)	(15)	(236)	58.4%

Table 3.3 Present for Family Death - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(396)	
Yes	(27)	(54)	(48)	(20)	(15)	(164)	41.4%
No	(15)	(82)	(77)	(30)	(28)	(232)	58.6%
Q14. I think most hospitals would allow family members to be present during resuscitation.						(411)	
Yes	(11)	(22)	(80)	(42)	(17)	(172)	41.8%
No	(12)	(33)	(129)	(44)	(21)	(239)	58.2%
Q15. I think it is an invasion of privacy to have family members present.						(342)	
Yes	(13)	(31)	(65)	(23)	(17)	(149)	43.6%
No	(12)	(50)	(73)	(22)	(36)	(193)	56.4%
Q16. The CPR team could perform their duties better if family members were not watching them.						(406)	
Yes	(40)	(50)	(41)	(15)	(21)	(167)	41.1%
No	(29)	(78)	(80)	(24)	(28)	(239)	58.9%

Table 3.3 Present for Family Death - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q17. My family has a high probability of not surviving CPR.						(414)	
Yes	(12)	(24)	(72)	(43)	(23)	(174)	42.0%
No	(8)	(29)	(92)	(73)	(38)	(240)	58.0%

Table 3.4 Wishes Made Known: Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.						(428)	
Yes	(47)	(122)	(47)	(32)	(8)	(256)	59.8%
No	(31)	(78)	(33)	(11)	(19)	(172)	40.2%
Q2. I would like to have my loved one with me if CPR was performed on me.						(409)	
Yes	(48)	(62)	(69)	(37)	(27)	(243)	59.4%
No	(26)	(51)	(52)	(18)	(19)	(166)	40.6%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.						(423)	
Yes	(38)	(72)	(88)	(33)	(21)	(251)	59.3%
No	(27)	(57)	(57)	(20)	(11)	(172)	40.7%
Q4. I think it would reassure my family member if I was at their bedside.						(418)	
Yes	(65)	(94)	(48)	(22)	(22)	(251)	60.0%
No	(32)	(74)	(28)	(8)	(25)	(167)	40.0%

Table 3.4 Wishes Made Known: Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(354)	
Yes	(23)	(37)	(74)	(52)	(22)	(208)	58.8%
No	(14)	(26)	(52)	(26)	(28)	(146)	41.2%
Q6. I need to stay out of the way so the CPR team can do their job.						(432)	
Yes	(151)	(87)	(10)	(3)	(8)	(259)	60.0%
No	(82)	(73)	(11)	(2)	(5)	(173)	40.0%
Q7. I don't think the emergency team would want me there.						(421)	
Yes	(86)	(113)	(25)	(9)	(21)	(254)	60.3%
No	(40)	(86)	(15)	(7)	(19)	(167)	39.7%
Q8. I have a right to be with my family member in any situation.						(416)	
Yes	(72)	(86)	(55)	(18)	(17)	(248)	59.6%
No	(35)	(67)	(42)	(7)	(17)	(168)	40.4%

Table 3.4 Wishes Made Known: Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.						(425)	
Yes	(38)	(69)	(84)	(40)	(25)	(256)	60.2%
No	(23)	(64)	(56)	(20)	(6)	(169)	39.8%
Q10. I want to be able to touch my loved one during the CPR process.						(408)	
Yes	(22)	(54)	(93)	(49)	(29)	(247)	60.5%
No	(1)	(25)	(76)	(20)	(29)	(161)	39.5%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(414)	
Yes	(34)	(62)	(82)	(35)	(34)	(247)	59.7%
No	(20)	(60)	(44)	(23)	(20)	(167)	40.3%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(420)	
Yes	(53)	(65)	(90)	(38)	(15)	(251)	59.8%
No	(25)	(60)	(49)	(19)	(16)	(169)	40.2%

Table 3.4 Wishes Made Known: Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(415)	
Yes	(35)	(78)	(71)	(36)	(30)	(250)	60.2%
No	(16)	(68)	(47)	(15)	(19)	(165)	39.8%
Q14. I think most hospitals would allow family members to be present during resuscitation.						(417)	
Yes	(16)	(47)	(109)	(41)	(37)	(250)	60.0%
No	(11)	(36)	(65)	(17)	(38)	(167)	40.0%
Q15. I think it is an invasion of privacy to have family members present.						(353)	
Yes	(13)	(21)	(100)	(51)	(22)	(207)	58.6%
No	(7)	(14)	(79)	(20)	(26)	(146)	41.4%
Q16. The CPR team could perform their duties better if family members were not watching them.						(423)	
Yes	(55)	(83)	(59)	(22)	(33)	(252)	59.6%
No	(30)	(72)	(30)	(15)	(24)	(171)	40.4%

Table 3.4 Wishes Known: Pretest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q17. My family has a high probability of not surviving CPR.						(411)	
Yes	(21)	(64)	(56)	(17)	(87)	(245)	59.6%
No	(15)	(43)	(29)	(11)	(68)	(166)	40.4%

Table 3.5 Wishes Made Known - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q1. The CPR team can deny family in the room during CPR.						(408)	
Yes	(41)	(117)	(52)	(23)	(11)	(244)	59.8%
No	(23)	(81)	(35)	(12)	(13)	(164)	40.2%
Q2. I would like to have my loved one with me if CPR was performed on me.						(397)	
Yes	(42)	(84)	(57)	(27)	(26)	(236)	59.4%
No	(35)	(52)	(41)	(13)	(20)	(161)	40.6%
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.						(410)	
Yes	(33)	(74)	(73)	(37)	(28)	(245)	59.8%
No	(22)	(58)	(51)	(19)	(15)	(165)	40.2%
Q4. I think it would reassure my family member if I was at their bedside.						(407)	
Yes	(57)	(99)	(51)	(15)	(24)	(246)	60.4%
No	(32)	(73)	(24)	(7)	(25)	(161)	39.6%

Table 3.5 Wishes Made Known - Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q5. Being with my loved one during CPR would be a spiritual experience for me.						(344)	
Yes	(24)	(40)	(67)	(41)	(29)	(201)	58.4%
No	(20)	(24)	(49)	(22)	(28)	(143)	41.6%
Q6. I need to stay out of the way so the CPR team can do their job.						(416)	
Yes	(101)	(113)	(15)	(7)	(12)	(248)	59.6%
No	(52)	(87)	(14)	(9)	(6)	(168)	40.4%
Q7. I don't think the emergency team would want me there.						(404)	
Yes	(57)	(115)	(36)	(8)	(28)	(244)	60.4%
No	(25)	(74)	(28)	(8)	(25)	(160)	39.6%
Q8. I have a right to be with my family member in any situation.						(408)	
Yes	(70)	(86)	(64)	(12)	(14)	(246)	60.3%
No	(41)	(68)	(37)	(4)	(12)	(162)	39.7%

Table 3.5 Wishes Made Known- Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q9. I don't know if I could emotionally handle watching CPR.						(414)	
Yes	(38)	(66)	(80)	(42)	(23)	(249)	60.1%
No	(18)	(61)	(52)	(22)	(12)	(165)	39.9%
Q10. I want to be able to touch my loved one during the CPR process.						(393)	
Yes	(33)	(53)	(92)	(30)	(26)	(234)	59.5%
No	(23)	(36)	(64)	(16)	(20)	(159)	40.5%
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.						(402)	
Yes	(23)	(62)	(81)	(41)	(32)	(239)	59.5%
No	(187	(52)	(53)	(19)	(22)	(163)	40.5%
Q12. I would need to be there to make sure everything was being done to save my loved one's life.						(405)	
Yes	(42)	(80)	(81)	(27)	(13)	(243)	60.0%
No	(27)	(65)	(51)	(10)	(9)	(162)	40.0%

Table 3.5 Wishes Made Known- Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.						(397)	
Yes	(26)	(79)	(77)	(33)	(24)	(239)	60.2%
No	(16)	(57)	(49)	(17)	(19)	(158)	39.8%
Q14. I think most hospitals would allow family members to be present during resuscitation.						(412)	
Yes	(16)	(29)	(126)	(59)	(16)	(246)	59.7%
No	(7)	(26)	(84)	(27)	(22)	(166)	40.3%
Q15. I think it is an invasion of privacy to have family members present.						(343)	
Yes	(13)	(42)	(83)	(32)	(31)	(201)	58.6%
No	(12)	(39)	(56)	(13)	(22)	(142)	41.4%
Q16. The CPR team could perform their duties better if family members were not watching them.						(407)	
Yes	(44)	(71)	(77)	(24)	(28)	(244)	60.0%
No	(25)	(57)	(45)	(15)	(21)	(163)	40.0%

Table 3.5 Wishes Made Known- Posttest

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure	Total	
Q17. My family has a high probability of not surviving CPR.						(415)	
Yes	(10)	(34)	(99)	(73)	(35)	(251)	60.5%
No	(10)	(19)	(66)	(43)	(26)	(164)	39.5%

Appendix Four

Individual Comparison Using t-Test

Table 4.0 Individual Pretest/Posttest Comparison Using t-test

Survey Question	Mean	St. Dev.	t-test	Sig.
Q1. The CPR team can deny family in the room during CPR.	-0.023	1.042	-0.434	0.664
Q2. I would like to have my loved one with me if CPR was performed on me.	-0.818	1.009	-1.579	0.115
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	0.886	1.138	1.548	0.122
Q4. I think it would reassure my family member if I was at their bedside.	-0.130	1.082	-0.235	0.814
Q5. Being with my loved one during CPR would be a spiritual experience for me.	-0.021	0.790	-0.481	0.631
Q6. I need to stay out of the way so the CPR team can do their job.	0.280	0.807	7.032	0.000***
Q7. I don't think the emergency team would want me there.	0.255	1.242	4.087	0.000***

Table 4.0 Individual Pretest/Posttest Comparison Using t-test

Survey Question	Mean	St. Dev.	t-test	Sig.
Q8. I have a right to be with my family member in any situation.	-0.074	0.892	-1.637	0.102
Q9. I don't know if I could emotionally handle watching CPR.	0.056	0.911	1.250	0.212
Q10. I want to be able to touch my loved one during the CPR process.	-0.254	0.914	-5.429	0.000***
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	0.840	1.003	1.066	0.098
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	-0.159	0.831	-3.808	0.000***
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	0.125	1.010	0.252	0.801
Q14. I think most hospitals would allow family members to be present during resuscitation.	-0.013	1.346	-0.186	0.085
Q15. I think it is an invasion of privacy to have family members present.	-0.195	1.420	-2.529	0.012**

Table 4.0 Individual Pretest/Posttest Comparison Using t-test

Survey Question	Mean	St. Dev.	t-test	Sig.
Q16. The CPR team could perform their duties better if family members were not watching them.	0.063	1.142	1.102	0.271
Q17. My family has a high probability of not surviving CPR.	-0.028	1.282	-0.434	0.665

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Appendix Five

Chi-Square Pretest and Posttest

Table 5.0 Age: Chi-Square Pretest and Posttest

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q1. The CPR team can deny family in the room during CPR.	6.51	.591	8.39	.391
Q2. I would like to have my loved one with me if CPR was performed on me.	12.16	.144	24.82	.002**
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	10.73	.218	14.37	.073
Q4. I think it would reassure my family member if I was at their bedside	12.66	.124	14.00	.083
Q5. Being with my loved one during CPR would be a spiritual experience for me.	3.96	.861	14.91	.061
Q6. I need to stay out of the way so the CPR team can do their job.	4.13	.844	11.77	.162
Q7. I don't think the emergency team would want me there.	14.35	.073	8.32	.403
Q8. I have a right to be with my family member in any situation.	7.35	.499	10.54	.229
Q9. I don't know if I could emotionally handle watching CPR.	8.48	.388	4.46	.813
Q10. I want to be able to touch my loved one during the CPR process.	13.23	.104	7.49	.485

Table 5.0 Chi-Square Age: Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q11. Because my loved one is not awake, hey wouldn't know if I was there anyway.	2.78	.947	14.72	.065
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	8.38	.398	12.89	.116
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	21.83	.005**	6.037	.533
Q14. I think most hospitals would allow family members to be present during resuscitation.	12.39	.135	5.00	.758
Q15. I think it is an invasion of privacy to have family members present.	4.36	.823	19.46	.013*
Q16. The CPR team could perform their duties better if family members were not watching them.	8.86	.354	2.75	.949
Q17. My family has a high probability of not surviving CPR.	5.66	.6.85	5.21	.735

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.1 Chi-Square Gender: Pretest and Posttest

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q1. The CPR team can deny family in the room during CPR.	9.62	.047	.84	.993
Q2. I would like to have my loved one with me if CPR was performed on me.	2.69	.611	1.40	.845
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	3.08	.544	3.37	.498
Q4. I think it would reassure my family member if I was at their bedside	4.55	.337	5.15	.272
Q5. Being with my loved one during CPR would be a spiritual experience for me.	.729	.948	4.44	.349
Q6. I need to stay out of the way so the CPR team can do their job.	5.17	.271	4.42	.352
Q7. I don't think the emergency team would want me there.	1.94	.747	1.21	.876
Q8. I have a right to be with my family member in any situation.	3.82	.431	1.52	.824
Q9. I don't know if I could emotionally handle watching CPR.	12.44	.014*	7.74	.101
Q10. I want to be able to touch my loved one during the CPR process.	.829	.934	2.52	.641
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	10.76	.030*	11.96	.018*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.1 Chi-Square Gender: Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	3.74	.443	5.71	.222
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	.88	.927	6.13	.190
Q14. I think most hospitals would allow family members to be present during resuscitation.	2.58	.631	3.77	.438
Q15. I think it is an invasion of privacy to have family members present.	4.39	.356	2.10	.716
Q16. The CPR team could perform their duties better if family members were not watching them.	3.31	.507	7.57	.108
Q17. My family has a high probability of not surviving CPR.	7.25	.123	7.53	.110

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.2 Marital: Chi-Square Pretest and Posttest

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q1. The CPR team can deny family in the room during CPR.	19.93	.077	12.56	.387
Q2. I would like to have my loved one with me if CPR was performed on me.	14.32	.281	17.52	.131
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	10.64	.560	8.47	.747
Q4. I think it would reassure my family member if I were at the bedside	31.56	.002**	13.60	.327
Q5. Being with my loved one during CPR would be a spiritual experience for me.	12.65	.395	21.65	.042*
Q6. I need to stay out of the way so the CPR team can do their job.	7.22	.843	8.63	.734
Q7. I don't think the emergency team would want me there.	23.38	.025*	13.96	.304
Q8. I have a right to be with my family member in any situation.	11.73	.467	8.41	.752
Q9. I don't know if I could emotionally handle watching CPR.	17.87	.120	7.61	.815
Q10. I want to be able to touch my loved one during the CPR process.	13.28	.349	9.20	.685
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	18.67	.097	11.01	.528

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.2 Marital: Chi-Square Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	17.55	.130	21.14	.048*
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	16.02	.190	6.27	.902
Q14. I think most hospitals would allow family members to be present during resuscitation.	14.52	.269	12.42	.413
Q15. I think it is an invasion of privacy to have family members present.	8.95	.708	20.03	.066
Q16. The CPR team could perform their duties better if family members were not watching them.	10.06	.611	4.55	.971
Q17. My family has a high probability of not surviving CPR.	7.03	.856	11.55	.483

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.3 Education: Chi-Square Pretest and Posttest

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q1. The CPR team can deny family in the room during CPR.	2.18	.703	9.71	.046*
Q2. I would like to have my loved one with me if CPR was performed on me.	11.90	.018*	5.11	.276
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	5.97	.520	4.45	.348
Q4. I think it would reassure my family member if I was at their bedside	9.26	.055	10.37	.035
Q5. Being with my loved one during CPR would be a spiritual experience for me.	1.59	.811	1.82	.769
Q6. I need to stay out of the way so the CPR team can do their job.	7.07	.132	6.92	.140
Q7. I don't think the emergency team would want me there.	0.47	.976	13.60	.009*
Q8. I have a right to be with my family member in any situation.	0.98	.913	2.47	.649
Q9. I don't know if I could emotionally handle watching CPR.	2.60	.628	5.74	.220
Q10. I want to be able to touch my loved one during the CPR process.	5.05	.282	4.25	.373
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	3.89	.422	2.89	.576

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.3 Education: Chi-Square Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	13.72	.008**	9.56	.049*
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	6.90	.142	7.54	.110
Q14. I think most hospitals would allow family members to be present during resuscitation.	6.95	.138	7.26	.123
Q15. I think it is an invasion of privacy to have family members present.	2.69	.611	2.16	.707
Q16. The CPR team could perform their duties better if family members were not watching them.	9.81	.044*	11.84	.019*
Q17. My family has a high probability of not surviving CPR.	13.09	.011*	11.05	.026*

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.4 Ethnicity: Chi-Square Pretest and Posttest

	Pretest		Posttest	
	χ^2	P-value	χ^2	P-value
Q1. The CPR team can deny family in the room during CPR.	16.04	.450	13.83	.611
Q2. I would like to have my loved one with me if CPR was performed on me.	14.44	.566	18.63	.289
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	18.67	.286	15.72	.473
Q4. I think it would reassure my family member if I was at their bedside	12.79	.688	19.30	.253
Q5. Being with my loved one during CPR would be a spiritual experience for me.	30.97	.013*	18.45	.298
Q6. I need to stay out of the way so the CPR team can do their job.	23.97	.090	36.25	.003*
Q7. I don't think the emergency team would want me there.	8.70	.925	19.40	.223
Q8. I have a right to be with my family member in any situation.	19.86	.227	23.52	.100
Q9. I don't know if I could emotionally handle watching CPR.	25.25	.065	19.94	.223
Q10. I want to be able to touch my loved one during the CPR process.	21.75	.152	19.01	.264
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	29.18	.023*	16.26	.435

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.4 Ethnicity: Chi-Square Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.45	.422	30.27	.017*
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	19.72	.233	11.74	.761
Q14. I think most hospitals would allow family members to be present during resuscitation.	16.79	.399	22.75	.121
Q15. I think it is an invasion of privacy to have family members present.	15.22	.509	13.77	.611
Q16. The CPR team could perform their duties better if family members were not watching them.	23.41	.103	32.10	.008**
Q17. My family has a high probability of not surviving CPR.	15.50	.489	20.754	.188

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

Table 5.5 Religion: Chi-Square Pretest and Posttest

	Pretest χ^2	P-value	Posttest χ^2	P-value
Q1. The CPR team can deny family in the room during CPR.	22.30	.034*	16.44	.189
Q2. I would like to have my loved one with me if CPR was performed on me.	15.16	.233	13.97	.303
Q3. I think it would be too traumatic for me to be present with my family member during the CPR.	13.99	.301	11.70	.470
Q4. I think it would reassure my family member if I was at their bedside	9.88	.626	13.99	.302
Q5. Being with my loved one during CPR would be a spiritual experience for me.	12.87	.379	13.91	.306
Q6. I need to stay out of the way so the CPR team can do their job.	5.66	.932	16.89	.154
Q7. I don't think the emergency team would want me there.	11.03	.527	10.92	.563
Q8. I have a right to be with my family member in any situation.	11.91	.453	8.81	.719
Q9. I don't know if I could emotionally handle watching CPR.	6.85	.862	17.61	.128
Q10. I want to be able to touch my loved one during the CPR process.	13.32	.346	16.01	.191
Q11. Because my loved one is not awake, they wouldn't know if I was there anyway.	18.99	.089	13.00	.369

Table 5.5 Religion: Chi-Square Pretest and Posttest

	Pretest		Posttest	
	χ^2	**P-value**	χ^2	**P-value**
Q12. I would need to be there to make sure everything was being done to save my loved one's life.	16.12	.186	13.72	.319
Q13. I would rather be in another room with the other family members waiting for the CPR team to finish.	12.27	.424	16.25	.180
Q14. I think most hospitals would allow family members to be present during resuscitation.	9.68	.644	13.39	.342
Q15. I think it is an invasion of privacy to have family members present.	16.18	.183	9.86	.628
Q16. The CPR team could perform their duties better if family members were not watching them.	10.06	.611	17.71	.125
Q17. My family has a high probability of not surviving CPR.	13.45	.337	9.06	.698

Significant Level: (*) for 0.05, (**) for 0.01, and (***) for 0.001

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