Witnessed resuscitation - exploring the attitudes and practices of the emergency staff working in Level I Emergency Departments in the province of KwaZulu-Natal

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Abstract

Aim: The aim of this study was to explore the attitudes and practices of witnessed resuscitation by the staff working in Level I Emergency Departments in the province of KwaZulu-Natal. Witnessed resuscitation involves the 'medical' resuscitation of the patient with their relatives or loved ones present in the resuscitation room (Boyd, 2000:171).

Methodology: A qualitative approach was used to explore the participants' attitudes and practices of witnessed resuscitation using individual semi - structured interviews. The principle of theoretical saturation was applied and a total of six participants from two Level I Emergency Departments (one provincial and one private institution) were included in this study.

Findings: The emergency staff disliked the idea of witnessed resuscitation. They believed it to be a harmful experience for the witnesses, a threat to the resuscitation process and the emergency staff, and impossible to implement in their Emergency Departments. There were however, subtle references made during the interviews that revealed some aspects of witnessed resuscitation that the staff favoured once they had considered the practice. There were no written policies to dictate how the relatives were handled, but all the staff agreed that the relatives were asked to wait outside the resuscitation area, were kept informed and then brought in when the patient was stable or had died. A number of recommendations are suggested in an attempt to introduce witnessed resuscitation as an option in KwaZulu-Natal's Emergency Departments.

Uittreksel

Doel: Die doel van hierdie studie was om die houdings en praktyk van personeel betreffende resussitasie wat in die teenwoordigheid van naasbestaandes uitgevoer word in vlak I Noodgevalle departemente in KwaZulu-Natal te bepaal. Daar word hierna verwys as "witnessed resuscitation" in the literatuur ((Boyd, 2000:171).

Metodologie: 'n Kwalitatiewe benadering was gebruik om die deelnemers se houdinge en praktyk betreffende resussitasie wat deur andere waargeneem word, te bepaal. Twee semigestruktureerde onderhoude is met elke deelnemer gevoer. Die beginsel van teoretiese versadiging het gegeld en 'n totaal van ses deelnemers van twee vlak I Noodgevalle departemente (een provinsiaal en een privaat organisasie) was in die studie ingesluit.

Bevindinge: Die Noodgevalle personeel het nie van die idee van resussitasie wat deur andere waargeneem word, gehou nie. Hulle het geglo dat dit 'n traumatiese ervaring vir die naasbestaande is, 'n bedreiging vir die personeel in die Noodgevalle departemente inhou en dat die onmoontlik is om dit in Noodgevalle departemente te implementeer. Daar was egter subtiele verwysings gedurende die onderhoude na resussitasie wat deur andere waargeneem word, wat getoon het dat daar sommige aspekte was waarvan hulle gehou het nadat oorweging aan die praktyk van van resussitasie wat deur andere waargeneem word, gegee is. Daar was geen geskrewe beleid betreffende die hantering van naasbestaandes nie, maar alle personeel het saamgestem dat die naasbestaandes gedurende resussitasie van 'n pasiënt gevra word om buite die resussitasie area te wag. Die naasbestaandes word ingelig gehou en weer in die eenheid toegelaat indien die pasiënt gestabiliseer of oorlede is. 'n Aantal aanbevelings word voorgestel as 'n opsie om resussitasie wat deur andere waargeneem word, in KwaZulu-Natal se Noodgevalle departemente te implementeer.

Introduction

Witnessed resuscitation, according to Boyd (2000:171) "is the process of active 'medical' resuscitation in the presence of family members". Witnessed resuscitation has not been the established norm in Emergency Departments internationally (Rattrie, 2000:32), although early reports of programmes created to promote witnessed resuscitation first appeared in the early 1980's (Boyd, 2000:171). There is much research available on the positive effects that witnessed resuscitation has on the family members, especially with regard to their improved ability to cope with the grieving process after the loss of their

loved one (Rattrie, 2000:32). However, the area of emergency staff's attitudes and practices with regard to witnessed resuscitation is an area that has not been as thoroughly researched. Available research has shown their attitudes to be mixed resulting in much debate over this practice (Rattrie, 2000:32). Furthermore, although limited research has been conducted internationally, it appears that no research into witnessed resuscitation has been conducted in KwaZulu-Natal or South Africa.

Purpose of the study

The purpose of this study was to explore the attitudes and practices of the emergency staff working in Level I Emergency Departments in KwaZulu-Natal, with regard to witnessed resuscitation.

Research question

What are the attitudes and practices of the emergency staff working in Level I Emergency Departments in the province of KwaZulu-Natal, with regards to witnessed resuscitation?

Objectives of the study

The objectives of this study were to:

- Explore the attitudes of the emergency staff with regards to witnessed resuscitation.
- Explore the practices of the emergency staff members with regards to witnessed resuscitation.

Definition of terms

Witnessed resuscitation

The definition used in this study is by Boyd (2000:171), who defines this term as "the process of active 'medical' resuscitation in the presence of the family members". It is the practice of allowing relatives into the resuscitation room while the emergency staff are attempting life saving measures on their loved one.

Attitudes

Attitudes are closely related to behaviour in that exploration of a person's attitudes can provide a better understanding of their behaviour. Attitudes are defined as "relatively stable clusters of feelings, beliefs, and behavioural predispositions" (Greenberg & Baron, 1997:170).

Practices

Practices are defined, as being "usual or customary action" (Hanks, 1989:1013). In this study the customary actions' of the emergency staff in dealing with relatives' requests to be allowed into the resuscitation area have been explored.

Emergency staff

This consisted of the professional health care providers, that is the doctors and nurses who work in Level I Emergency Departments and provide immediate, life saving medical attention to people in need thereof.

Level I Emergency Department

This is an Emergency Department that is designed, equipped and staffed to provide advanced life support to severely injured people. It is operational 24 hours a day, seven days a week and is approved at a national level against specific criteria.

Ethical considerations

Permission to conduct this research was obtained from the board of managers of the private hospital and from the medical superintendent of the provincial hospital, before the research was undertaken. Before starting the interviews, the participants were each informed of the research being undertaken, and that participation was voluntary. The participants were advised of their right to withdraw from the study at any point and this decision was respected. The interviews were taped, with the knowledge and verbal consent of the participants. Once the interviews had been transcribed, these tapes were destroyed - only the transcriber and the researcher had access to the recorded interviews before they were destroyed. The identity of the Emergency Departments and emergency staff involved in this study have been kept confidential. Each participant was asked to choose a pseudonym at the beginning of the initial interview, and this was used throughout the study.

Literature review

A survey of the available literature was carried out and focused on the experiences of family members and the attitudes of emergency staff.

Experiences of family members

A survey carried out amongst newly bereaved family members in Michigan in 1982 (Hanson & Strawser, 1992:104 - 106), revealed that 72% of the respondents wished that they had been present at the resuscitation of their family member. Gregory (1995:136), a senior charge nurse who was denied access to her daughter in the resuscitation area, records that she has a lasting memory of not being with her daughter, and that she regrets not just pushing her way into the resuscitation area to be with her. In an article by Doris (1994:43), the mother of a baby is quoted as saying "I want my voice to be the last that he hears, I want my touch to be the last he feels." The nurse with her stated that it was obvious it hadn't occurred to her that she wouldn't be with her son when he died. Cole (2000:para 1) cites an incident where the wife of a man critically injured in a road accident arrived in the Emergency Department whilst resuscitation of her husband was in progress. She requested to see him but was told she would be called when he was "more stable ". She finally got to see him an hour and a half later, once he had died. In another incident, a relative is quoted by Cole (2000:para 11) as saying "I would have loved to have held his hand but I didn't dare ask."

Research done on the effects of witnessed resuscitation on the 'witnesses' revealed that the experience is not harmful, and in the majority of the cases is actually emotionally beneficial. In a study done in Ohio (Belanger & Reed, 1997:239), the effects of witnessed resuscitation over a year were studied amongst relatives granted access into the resuscitation area and they reported better coping with the grieving process. A study conducted in Cambridge between November 1995 and

February 1997, by Robinson, Mackenzie-Ross, Campbell Hewson, Egleston and Prevost (1998:614) revealed that all the relatives that attended the resuscitation of their loved ones were content with their choice. Furthermore, when they were assessed three months after the witnessed resuscitation, a trend towards lower degrees of intrusive imagery, post-traumatic avoidance behaviour and symptoms of grief was found. Another interesting finding was that three of the patients that survived said that they had felt supported by the presence of family. Eichhorn, Meyers, Thomas & Cathie (1996:64) showed in a study that the feeling of anguish over not being with the loved one was paramount, and that through witnessed resuscitation the fear of being separated and alone without knowing what was happening to the loved one was eliminated. People were found to be able to cope better with their loss through being able to say goodbye still holding an alive or warm hand and knowing that the sense of hearing is the last sense to cease. Williams (1993:479), a registered nurse and clinical nurse specialist in crisis intervention, states, "Ultimately, I believe that the persons who must have authority to decide this issue are the ones most vested in the outcome - the family. They are also the ones who must learn to integrate the death into their lives." However, there are concerns amongst the emergency staff that result in the family being denied access to the resuscitation area.

Attitudes of the emergency staff

Emergency staff's attitudes towards witnessed resuscitation are mixed. Responses to questionnaires distributed by Mitchell & Lynch (1997:366), in which emergency staff were asked if they were in favour of the presence of selected relatives during a resuscitation, were predominantly negative. This finding was also supported by Osuagwu (1993:276). In contrast, is a study done by Chalk (1995:58), where questionnaires distributed randomly to medical and ambulance staff, showed the majority of the staff to be positive about witnessed resuscitation. Of this majority, the largest proportion were nurses, with doctors tending to be more reluctant. A study done by Back & Rooke (1994:34) showed that the majority of the staff agreed with the statement that relatives should have the opportunity to be with a family member during resuscitation, provided appropriate professional support was available.

Cole (2000:para 5 -10), gives an overview of staff concerns that prevent emergency staff from allowing witnessed resuscitation. There is the concern about sensory disturbance for the relatives which occurs as a result of the resuscitation process where life saving measures can appear potentially harmful. Blood, secretions and certain injuries such as burns can produce upsetting smells, and an unconscious patient or a patient in pain, can cry out. All of these experiences are perceived by emergency staff as being potentially upsetting for the patient's family to witness. This concern is also noted by Eichhorn et al (1996:63), who despite this regards witnessed resuscitation as being an integral part of preserving the family unit from birth to death. Cole (2000:para 12) suggests that there is a need to respect the wishes of the relatives, and that by allowing them to see that everything possible is being done, terrible imagery or anxiety may be alleviated. This author also proposes that television programmes mean that the public may not be as unfamiliar with the resuscitation process as the emergency staff believe.

Another concern is for patient confidentiality. Confidentiality cannot be maintained during witnessed resuscitation because the witnesses will also be listening to the discussions regarding the patient, and in this way may receive information without the patients' consent (Cole, 2000:para 6). This problem was addressed in a study by Robinson et al (1998:617) where three survivors of witnessed resuscitation expressed that they did not feel their confidentiality had been compromised.

Emergency staff reportedly also have a fear of litigation by the witnesses should a comment, action or procedure during the resuscitation, appear unacceptable to them (Cole, 2000:para 7 & Eichhorn et al,1996:63). However in a study by Robinson et al, (1998:617), it was found that none of the relatives that were allowed to witness the resuscitation of their family member commented on technical procedures done during the resuscitation.

Finally, there are also concerns that a grief-stricken relative may disrupt the resuscitation, or that the resuscitation team will be reluctant to stop a failed effort when the relatives are present urging the team to continue trying (Cole, 2000:para 10). A study done in Michigan, in the Foote Hospital (Hanson & Strawser, 1992:104), reported that no relatives interfered with the resuscitation during a trial of witnessed resuscitation, although it was reported that some relatives who became hysterical were led away from the resuscitation area. This study also reported that staff, through witnessed resuscitation, regarded the patient more holistically and that therefore witnessed resuscitation brought staff's emotions closer to the surface and made the resuscitation even more stressful for them.

The conceptual framework used in this study

Greenberg & Baron (1997:170) define attitudes as "relatively stable clusters of feelings, beliefs, and behavioural predispositions". Three major components of attitudes are recognised, namely, the 'evaluative component,' the 'cognitive component' and the 'behavioural component' (Greenberg & Baron, 1997:169). The evaluative component of the emergency staff's attitudes addresses their like or dislike of witnessed resuscitation, the cognitive component addresses their beliefs' about witnessed resuscitation, and the behavioural component refers to the emergency staff's tendencies to behave according to their feelings and beliefs about witnessed resuscitation. Although exploration of the behavioural component of a participant's attitudes will reveal their predisposition to behave in a certain way, this component cannot necessarily be predictive of their behaviour. As an example, a department policy that dictates actions that are inconsistent with the emergency staff's evaluative and cognitive components may cause their behaviour to be inconsistent with their attitudes. This framework, together with the literature reviewed, formed the conceptual framework for this study.

Research design

Research approach

This research took the form of a qualitative survey. The rationale for choosing this approach is that through the literature survey it became evident that the majority of the research done

Table 1: Profile of the participants

Pseudonym	Position in the Unit	Years in the Unit	Description of participants
SHAUN	Medical Officer	8 years	He had not participated in a witnessed resuscitation prior to this study. He had done Advanced Cardiac, Trauma and Paediatric Life Support and a diploma in Emergency Medicine and Care. He was married with children at the time of the study.
PENNY	Registered Nurse	2 years and 9 months	She had never participated in a witnessed resuscitation. She had worked in the same emergency department since she qualified. She had no children and was not married at the time of this study, however both of her parents and her sister lived in Durban.
LUCY	Registered Nurse in charge of the unit	9 months	She had participated in a witnessed resuscitation when working on an ambulance, the resuscitation occurred in the patients home. She did her diploma in trauma nursing in 1998. She was married at the time of this study.
BOB	Registered Nurse in charge of the unit	8 years	He had not participated in a witnessed resuscitation. He had been in charge of the emergency department for two years. His brother died in a motor vehicle collision.
BONGI	Registered Nurse	2 and a half years	She had not participated in a witnessed resuscitation. She had no post basic training. She had had a baby boy nine months previously.
SIMBA	Medical Officer	2 years	He had participated in a witnessed resuscitation in the emergency department in a situation where the relatives had refused to leave the resuscitation area. He had done Advanced Cardiac, Trauma and Paediatric Life Support and was currently studying a diploma in Emergency Medicine and Care.

internationally on the attitudes of the emergency staff towards witnessed resuscitation, had been done through anonymous questionnaires. This quantitative approach may not have provided a holistic study of attitudes and practices. Thus a qualitative approach allowed for a thorough, individual exploration of the participants' attitudes and practices. (Polit & Hungler, 1993:326).

Participants and the setting

The participants in this study were the doctors and registered nurses working in two Level I Emergency Departments in the province of KwaZulu-Natal (see Table 1 for a Profile of the participants). It is a combination of the attitudes of both the clinical staff (the nurses employed in the department) and managerial staff (the doctors and nurses in charge of the departments) that determine what is practised in the Emergency Departments. Thus the researcher's sample comprised of key clinical and managerial informants, chosen through purposive sampling, from one of the two private Level I Emergency Departments, and one of the two provincial Level I Emergency Departments in the province of KwaZulu-Natal. The participants needed to have been employed in the department for more than six months, in order to ensure that they had sufficient exposure to the resuscitation process. Specialized emergency training was not required as a criterion and the principle of theoretical saturation was applied.

Data collection

After gaining access to the hospitals, the researcher introduced herself and the research subject to the emergency staff (both clinical and managerial) in the respective departments. Each participant was informed about who the researcher was, why the research was being done and how confidentiality was to be maintained. The participants were found to be willing to participate in the study, and none of the participants chose to withdraw. A doctor, the nurse in charge of the department and a nurse working in the department were interviewed from each of the respective hospitals. At the start of each interview a pseudonym was chosen by each of the participants in order that their identity remained confidential, and permission was granted to tape the interviews. Two semi-structured interviews were conducted per participant by the researcher with each lasting approximately 20 to 30 minutes. The first interviews were based on a set of six questions and the second interviews were verifying interviews, to confirm the interpretation of the data collected in the first interview (see Table 2 for the interview guide). The researcher waited until the department was quiet and the staff were available to be interviewed. The interviews were then conducted in the Emergency Departments in a quiet room and 'Do not disturb' signs were placed on the doors.

Table 2: The interview guide

1.	How many years have you been employed in the Emergency Department and currently what position do you hold?
2.	What do you understand by the term "witnessed resuscitation?
3.	What are your thoughts regarding witnessed resuscitation?
4.	Do relatives ask to be allowed to witness the resuscitation of their family members? If so, how frequently and what is your answer and why?
5.	Have you been involved in a witnessed resuscitation, if so what do you think about the experience?
6.	Does your department have any policies to deal with the relatives of a person being resuscitated? If so, what is the policy, who designed it, and is it practiced?
7.	If a member of your family was being resuscitated, would you want to be present and witness his/her resuscitation and why?
8.	How do you think you would feel if a member of your family was allowed to be in the resuscitation area while you were being resuscitated?

Data analysis

The recorded data were transcribed into written text by the researcher and a person trained in transcribing. The data were then manually analysed using qualitative context analysis to derive patterns and themes from the recorded data (Brink, 1996:192). The conceptual framework used in this study divided attitudes into three components, namely the evaluative, the cognitive and the behavioural components. Thus the major findings of this study are presented within these three components, and an outline of the categories and sub-categories derived from the data can be found in Table 3.

Trustworthiness

Four recognized and commonly used criteria for establishing the trustworthiness of qualitative data are credibility, transferability, dependability and confirmability (Polit & Hungler, 1993:254). In applying these concepts to the study the following steps were taken. The verifying interviews used in this study provided one of the main techniques used in establishing trustworthiness. In these interviews the research participants reviewed, validated and verified the researcher's interpretations and conclusions of the participants experiences. Any data that was unclear or required further exploration, was clarified. Detailed descriptions of the research process were also provided to enable the reader to get a sense of "being there" and were also used in the study to enable others to determine whether the findings of the study were applicable to another context. Through the recording and transcribing of the interviews, a means for independent analysis of the researcher's interpretations, by a more experienced researcher, was provided (Polit & Hungler, 1993:255). The researcher also made use of bracketing to examine her own values, experiences and assumptions about the attitudes and practises of emergency staff towards witnessed resuscitation in Emergency Departments (Brink, 1996:120).

Findings and discussion

A total of six emergency staff members were interviewed, and the data consisted of a total of twelve interviews. A profile of the participants is included in Table 1.

The evaluative component of staff attitudes

It was evident in this study that witnessed resuscitation was a new and unexplored topic amongst the emergency staff. The participants in this study were found to have little knowledge about witnessed resuscitation or the ongoing debate over the implementation of this practice, unlike their international counterparts (Rattrie, 2000:32). In illustration, SHAUN defined witnessed resuscitation as *"...how we perceive the resuscitation to have gone..."*, and both PENNY and LUCY described witnessed resuscitation to be the situation where the arrest of the patient is witnessed by an emergency staff member who then immediately implements life saving measures. The researcher thus had to spend time explaining what was meant by "witnessed resuscitation" in this research before the interviews could commence.

The initial and overriding feelings of all of the staff in this study was a dislike of the idea and the practice of witnessed resuscitation. Some participants were more strongly against having the relatives in the resuscitation room than others, for example SIMBA said *"I totally disagree with allowing family members into the resuscitation room..."* whereas PENNY said *"I don't think it's nice..."*. The staff didn't think that the relatives should be present at the resuscitation of their loved one, and they said they preferred not to be present at the resuscitation of their own family members. LUCY expressed her feelings in the following words, *"...with every patient you just log on, do your work and that's it. It's not Mr so and so. It is a patient, a person with an aortic aneurysm, it's a person with*

Table 3: Categories and sub-categories derived from the data

Categories		Sub-categories
Attitudes	Evaluative component	• "Not a good idea" • "Maybe not so bad"
	Cognitive component	• "Hurting the body" • Limited resources • "Getting in the way" • Unsatisfied relatives • "Maybe it could work"
	Behavioural component	• Preventing witnessed resuscitation
Practices		• "What is practiced" • Relatives requests to be present • Staff experiences of witnessed resuscitation • "More than a change of heart?"

bilateral femoral fractures, it is not a patient with a name and that." She went on to explain why she would not like to be present at the resuscitation of her own family saying; *"...you are going to be in the way because you are emotionally involved."* The participants also confirmed that they would rather their families did not witness their resuscitation should they require it someday. BONGI summarised the participants' feelings as follows, *"I'd prefer to hear of the results of it, what happened, but I wouldn't like to be there."* These findings are in keeping with those of Mitchell & Lynch (1997:366) and Osuagwu (1993:276).

However, by the end of the interviews, the researcher found some of the participants to be more interested and receptive to the concept of witnessed resuscitation than when the topic was initially introduced to them. BOB reported liking the idea of having the opportunity to talk to his family member during their resuscitation. Towards the end of his initial interview, SHAUN, after saying that he didn't think his wife would want to be present at his resuscitation, said that if his wife insisted on being there he would not have any objection. Eichhorn et al (1996:69), report similar findings in that they perceived a change in people's attitudes towards witnessed resuscitation after an initiation program, when more acceptance of the idea made the possibility of implementing witnessed resuscitation seem less remote than before.

The cognitive component of staff attitudes

The participants had numerous reasons for their overriding dislike of the practice of witnessed resuscitation. They were concerned about the sensory disturbances that would be experienced by the witnesses, PENNY stated *"It's kind of...I mean people pressing on your chest, ribs breaking and things like that."* Other measures specifically mentioned by the staff were, the insertion of chest drains, defibrillating, putting in pipes, sticking in needles and intubation. All of these are invasive procedures that are, as LUCY mentioned, *"abnormal in their* (the relatives) *eyes,"* and therefore difficult for the relatives to witness. The staff were also concerned that the witnesses would suffer post-traumatic trauma in the form of flash-backs and in terms of what they remembered of their loved one. SHAUN summarised the staffs' feelings in the following words... *"I don't think it's good for the family to have that image in their mind of their loved ones essentially being hurt..."* The staff were also concerned that the resuscitative process would be rendered less effective because of the family presence and that the resuscitation would be more stressful for the emergency staff. SIMBA stated, *"...they* (the family) *tend to get in the way - and the mourning - and it changes the mood of the room. It also impacts on the people trying to do the resuscitation."* There was also a shared concern that the relatives, who would be unsure of what resuscitation involved and why, would not understand what was done and would therefore be unsatisfied with staff efforts. BONGI stated *"Watching what is happening, you just take it in your own way if you don't know exactly what is going on and then, you know, that causes a misunderstanding and at the end of the day maybe the relative would not be satisfied with what happened..."* In contrast to the experiences and fears of the participants in this study, are the results of a study done in Michigan, in the Foote Hospital (Hanson & Strawser, 1992:104), where no relatives interfered with the resuscitation.

Staff did often conclude the interviews by discussing the resources that would be necessary in order to have witnessed resuscitation in their Department. They were concerned about the limited space in the resuscitation area and the lack of staff available to support the witnesses.

The behavioural component of staff attitudes

The emergency staff's dominant feelings were those of dislike, and their beliefs provided reason for their dislike of the prac-

tice, thus they are perceived to have a predisposition not to allow witnessed resuscitation to take place in their department. Lucy summarized the general agreement amongst the emergency staff on how to deal with the relatives; "*...as soon as everything is stable and under control, get the people involved.* "

Emergency staff practices

It was found that neither of the Emergency Departments used in this study had written department policies dictating the handling of relatives of a patient being resuscitated. However the staff from both of the departments said that there was a general understanding amongst the staff that provided consistency in their dealing with these relatives. The relatives were always asked to wait outside the resuscitation area and were kept informed, as often as possible, about the resuscitation by members of the resuscitation team. Once the patient was stable the relatives would then be allowed into the room and their questions would be answered by the team. The practices of these staff confirm the findings of Eichhorn et al (1996:59).

There were mixed experiences by the staff with regard to relative requests to be present at the resuscitation of their loved one. It was evident that relatives often stayed with their family member until they were asked to leave, and some of the participants had experienced requests from the relatives to be present at the resuscitation of their family member. Certain incidences where the family were reluctant or refused to leave their relative's side were also reported. Only one participant had been part of a witnessed resuscitation in the Department in which he was employed prior to this study. The relatives of the patient had been asked to leave the resuscitation area but had refused and had therefore been present at the resuscitation of their family member. The family in this incident reportedly interfered with the resuscitation process and became hysterical when they realised that the emergency staff were terminating their efforts on confirmation that the patient was already dead.

SHAUN, a doctor, reported that in the week between his initial and his verifying interview he had participated in a witnessed resuscitation. His resuscitative efforts had been witnessed by two of the patient's colleagues, one of whom had medical training. The witnessed resuscitation reportedly went well and the witnesses reportedly appeared to have appreciated being allowed to stay. SHAUN felt that the experience had been beneficial to the witnesses and to the patient and reported no interference with the resuscitation process.

Limitations to the study

The fact that the interviews were carried out whilst the participants were on duty can be argued to have affected the participants in that they would have been aware that should they have been required in the department they would be called. It could also be argued that the recording of the interviews could have caused the participants to be less spontaneous in their responses than had they not been recorded. The presence of the researcher could also have influenced the participants' responses, in that they may have aimed to provide answers that they thought the researcher wanted to hear. The participants frequently used medical terminology and department 'slang', and this has meant that, for those readers who are not familiar with the emergency setting, understanding and interpreting the findings in this study could prove to be difficult. A further limitation is that this study has a small sample size, and therefore the findings cannot be generalised beyond the context of this study.

Recommendations

Further research with regard to witnessed resuscitation in KwaZulu-Natal is needed. There is a need for the wishes of the public to be explored, particularly in relation to the many different cultures and religious beliefs that co-exist in this province. Witnessed resuscitation trials should be conducted and through this the effects that it has on the witnesses could be studied, as well as the particular effects on the emergency staff and the resuscitative process. There is a need for research to be done to establish resources that would be needed to successfully implement a witnessed resuscitation programme. Should witnessed resuscitation be implemented, it is recommended that the concept of witnessed resuscitation as well as the skills necessary for its implementation, be introduced in the undergraduate and post graduate training of emergency staff. Finally it is recommended that written policies addressing the issue of how to deal with the relatives of a patient being resuscitated be drafted and available in the Emergency Departments of KwaZulu-Natal, hereby providing substantiated and informed reasoning for the actions expected from the emergency staff.

Conclusion

The emergency staff generally disliked the idea of witnessed resuscitation and relatives were usually asked to wait outside the resuscitation room. It does however appear that the emergency staff, in the Level I Emergency Departments of KwaZulu-Natal may become more receptive to the practice of witnessed resuscitation and provide this option to those people that want to remain with their loved one during their resuscitation.

References

BACK, D & ROOKE, V 1994: The presence of relatives in the resuscitation room. Nursing Times. 90(30) : 34-35.

BELANGER, M & REED, S 1997: A rural community hospital's experience with family-witnessed resuscitation. Journal of Emergency Nursing. 23(3) : 239-239.

BOYD, R 2000: Witnessed resuscitation by relatives. Resuscitation. 43(3) : 171-176.

BRINK, H 1996: Fundamentals of Research Methodology for Health Care Professionals. South Africa: Creda Press (pty) Ltd.

CHALK, A 1995: Should relatives be present in the resuscitation room? Accident and Emergency Nursing. 3 : 58-61.

COLE, E 2000: Witnessed Trauma Resuscitation - can relatives be present? Trauma.org, [19 paragraphs]. Available at http://www.trauma.org.

DORIS, K F 1994: A Chance to Say Goodbye. American Journal of Nursing. May : 42-45.

EICHHORN, D, MEYERS, T, THOMAS, G, & CATHIE, E

1996: Opening the doors: family presence during resuscitation. Journal of Cardiovascular Nursing. 10(4) : 59-70.

GREENBERG, J & BARON, RA 1997: Behaviour in organizations. 7th edition. New Jersey: Prentice-Hall Inc.

GREGORY, C 1995: I should have been with Lisa when she died. Accident and Emergency Nursing. 3 : 136-138.

HANKS, P 1989: Collins Concise Dictionary Plus. Glascow: The Bath Press.

HANSON, C & STRAWSER, D 1992: Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine year perspective. Journal of Emergency Nursing. 18(2) : 104-108.

MITCHELL, M & LYNCH, M 1997: Should relatives be allowed in the resuscitation room? Journal of Accident and Emergency Medicine. 14(6) : 366-369.

OSUAGWU, C 1993: More on family presence during resuscitation. Journal of Emergency Nursing. 19(49) : 276-277.

POLIT, DF & HUNGLER, BP 1993: Essentials of Nursing research. Methods, Appraisals and Utilization. Philadelphia. J. B. Lippincott Company.

RATTRIE, E 2000: Witnessed resuscitation: good practice or not? Nursing Standard. 14(24) : 32-34.

ROBINSON, SM, MACKENZIE-ROSS, S, CAMPBELL HEWSON, GL, EGLESTON, CV & PREVOST, AT 1998: Psychological effect of witnessed resuscitation on bereaved relatives. Lancet. 22(352) : 614-617.

WILLIAMS, M 1993: More on family presence during resuscitation. Journal of Emergency Nursing. 19(6) : 478-479.

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