Attitudes Toward and Beliefs About Family Presence: A Survey of Healthcare Providers, Patients' Families, and Patients

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CE 2.0 Hours

Notice to CE enrollees:
A closed-book, multiple-choice examination following this article tests your understanding of the following objectives:

1. Discuss current attitudes about family presence during resuscitation and/or invasive procedures.
2. Review the current literature concerning family presence related to both healthcare providers and patients and patients' families.
3. Describe family presence survey results, conclusions, and recommendations.

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EBR Evidence-Based Review on pp 281-282.

This article is followed by an *AJCC* Patient Care Page on page 283.

Background Although some healthcare providers remain hesitant, family presence, defined as the presence of patients' family members during resuscitation and/or invasive procedures, is becoming an accepted practice. Evidence indicates that family presence is beneficial to patients and their families.
Objectives To describe and compare the beliefs about and attitudes toward family presence of clinicians, patients' families, and patients.
Methods Clinicians, patients' families, and patients in the emergency department and adult and neonatal intensive care units of a 300-bed urban academic hospital were surveyed.
Results Surveys were completed by 202 clinicians, 72 family members, and 62 patients. Clinicians had positive attitudes toward family presence but had concerns about safety, the emotional responses of the family members, and performance anxiety. Nurses had more favorable attitudes toward family presence than physicians did. Patients and their families had positive attitudes toward family presence.
Conclusions Family presence is beneficial to patients, patients' families, and healthcare providers. As family presence becomes a more accepted practice, healthcare providers will need to accommodate patients' families at the bedside and address the barriers that impede the practice. (American Journal of Critical Care. 2007;16:270-282)

Family presence, defined as the attendance of patients' family members during resuscitation and/or invasive procedures, has a place in the context of family-centered care. Family-centered care is an approach in which care is provided not only for patients but also for the patients' families.[1] The underlying premise is that each patient is an extension of a larger unit: his or her family. The goal of family-centered care is to meet the needs of patients' families, including their needs for information and support and the opportunity to be near their loved ones.[1,2] Research[2-4] has repeatedly shown that patients' family members have certain needs during a health-related crisis, including having honest, consistent, and thorough communication with healthcare providers, being physically and emotionally close to the patient, feeling that healthcare providers care about the patient, seeing the patient frequently, and knowing exactly what has been done to the patient. Family presence during resuscitation and/or invasive procedures may meet these needs and is one way patient- and family-centered care can be operationalized. In addition, family presence fulfills a patient's need for support from a loved one.

Literature Review

A wealth of literature[5-10] is available on family presence in pediatric settings. Parents clearly want to be present during their child's resuscitation and/or invasive procedure and feel that it is beneficial to themselves and their child. In addition, pediatric healthcare providers are more accepting of the practice, especially if they have had previous experience with family presence.[11-16] The literature on family presence with adult patients includes many anecdotal accounts of both the positive and the negative effects of family presence.[17-23] The following literature review focuses on adult research-based studies.

Perspective of Healthcare Providers

Holistic healthcare providers care for patients and patients' families. Incorporating family presence supports both patients and their families.[24] Unfortunately, some healthcare providers still hesitate to adopt family presence. Investigators have examined healthcare providers' attitudes toward and beliefs about family presence. In a survey of emergency department physicians and nurses, Redley and Hood[25] found that healthcare providers had many concerns about patients' families being present during resuscitation procedures. Providers were concerned that the procedures would offend family members, that the staff would experience more emotional stress, that family members would be disruptive, that family presence would interfere with treatment, and that family members would not be prepared to deal with a resuscitation situation.

Healthcare providers surveyed felt that families witnessing resuscitation were not well prepared and may interfere with treatment, be disruptive, and cause stress among staff members.

Meyers et al[26] were the first to use the family presence protocol developed by the Emergency Nurses Association (ENA) to study the experiences of healthcare providers and patients' families. In that study, 96 healthcare providers and 39 family members who were involved in an episode of family presence reported positive attitudes toward family presence. Nurses had a significantly more positive attitude than did either attending or resident physicians. Attending physicians had a more positive attitude than did residents.

Healthcare providers in the study[26] believed that family presence helped meet the emotional and spiritual needs of a patient's family; empowered the family members; helped the family understand the patient's condition; gave the healthcare providers an opportunity

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to educate the family, possibly decreasing litigation; allowed the family to help both the patient and the staff; and caused the providers to be more considerate of the patient's dignity, privacy, and need for pain management. The providers reported that patients' family members acted appropriately during the event and that performance and outcomes were the same regardless of family presence. Some providers were concerned, however, that patients' family members might misinterpret the providers' actions or experience negative psychological effects.

Helmer et al[27] surveyed 1629 members of the American Association for the Surgery of Trauma (AAST) and the ENA to determine the members' opinions on family presence during trauma resuscitation. ENA members were significantly more open to family presence than were AAST members; these results are consistent with findings from other studies. ENA members thought that family presence was beneficial to patients and the patients' families and that patients had the right to have family members present. Both AAST and ENA members thought that the option of family presence should be extended only after all invasive procedures were complete and that allowing family presence increased the stress on staff. The study points out the difficulty of comparing family presence in trauma and nontrauma situations.

Nurses had significantly more positive attitudes toward family presence than did attending or resident physicians.

McClenathan et al[28] reported findings contrary to those of Meyers et al.[26] Among 554 professionals surveyed at a critical care conference, 343 had experience with family presence, and, of those, 40% would allow family presence again. A total of 80% of physicians and 61% of nurses and other allied health professionals were opposed to family presence. Psychological trauma to patients' families, performance anxiety of healthcare providers, and distractions by patients' family members were all cited as reasons to prohibit family presence.

Finally, in a survey of 948 members of the ENA and the American Association of Critical-Care Nurses, MacLean et al[29] found that only 5% of the nurses worked on units with a written family presence protocol. Healthcare providers who worked at institutions without written policies allowed family presence during resuscitation (45%) and invasive procedures (51%). Some survey participants preferred written policies for resuscitation (37%) and invasive procedures (35%), whereas other did not. MacLean et al speculated that this preference was due to nurses' uneasiness with the practice or the nurses' unwillingness to change current practice, which excluded family presence. A total of 36% and 44% of participants had taken patients' family members to the bedside during resuscitation and invasive procedures, respectively. Healthcare providers reported that patients' family members often asked to be present during resuscitation (31%) and invasive procedures (61%).

Nursing organizations have taken the lead in adopting family presence. This finding is not surprising, because the American Nurses Association Code of Ethics for Nurses speaks to nurses' primary responsibility as recognizing "the patient's place in the family or other networks of relationship."[30] The ENA position statement on family presence[31] recommends that the option of family presence be presented and that emergency nurses receive continuing education on the subject. As a result, the ENA has added content on family presence to the organization's courses on trauma nursing and emergency pediatric nursing.[32,33] In addition, the ENA has published a protocol for family presence.[34]

The American Association of Critical-Care Nurses issued a practice alert that calls for extending the option of family presence to patients' families.[35] (*Editor's note:* For an excerpt, see the *AJCC* Patient Care Page on page 283.) Other organizations that support the option of family presence include the National Association of Emergency Medical Technicians,[36] the National Association of Social Workers,[37] and the American Heart Association.[38] The American Heart Association guidelines[39] on cardiopulmonary resuscitation and emergency cardiovascular care now include recommendations for family presence.

Perspective of Patients' Families

Although healthcare providers are divided in their opinions about family presence, patients and patients' families feel differently. Doyle et al[39] surveyed 51 members of patients' families who had attended a loved one's resuscitation. Participants thought they were well informed about what to expect during the resuscitation (72%) and felt that staff communicated with them clearly (70%). In addition, 79% reported having physical contact with their loved one, and 61% talked with their loved one. The families felt that the healthcare providers had done everything possible for the families' loved ones; 76% thought that adjustment to death and grieving was made easier by being present, and 64% thought their presence was beneficial to the dying loved one.

Meyers et al[40] interviewed 39 members of patients' families after the members' experience with family

presence during resuscitation and/or invasive procedures. The family members reported that being present was beneficial to themselves and to their loved one because it was important to be helpful to their loved one; it made the family members realize the seriousness of their loved one's condition; it comforted the family because they were able to witness the care being provided to their loved one; it decreased worry and lessened helplessness; it facilitated grieving; and it caused healthcare providers to be more diligent in the care of the loved one. Family members also recognized the need to act appropriately and not interfere with the care provided. In addition, family members believed that it was their right to be present, and they wished to have the option of family presence extended to them.

No studies have indicated that having a patient's family members witness the patient's resuscitation and/or invasive procedures resulted in negative psychological effects. In research by Meyers et al[40] and Robinson et al,[41] patients' family members focused on the patient and not the situation and did not experience negative psychological effects; no family members regretted the decision to be present during the resuscitation.

Perspective of Patients

Eichhorn et al[42] gathered the first data on patients' attitudes and beliefs after the patients' families had been present during resuscitation and/or invasive procedures. The 9 patients who were interviewed said that they were comforted when family was present and believed that their family acted as advocates and provided important information to the healthcare providers. Family members thought that family presence reminded providers of a patient's personhood, helped maintain patient-family connectedness, and was the family members' right. As with family members, patients also understood that family presence was appropriate as long as the family did not interfere with care. Patients also realized that although having family members present offered immediate information to the members, the event might be distressing to their family members.

Although the data from studies of patients and patients' families show consistent trends toward acceptance of and even expectation of family presence, the data on healthcare providers continue to be contradictory.

Purpose

The purpose of our study was to describe and compare the attitudes toward and beliefs about family presence of healthcare providers, patients' family members, and patients regardless of previous experience with family presence.

Methods

Design

A descriptive survey design was used to generate quantitative data and qualitative comments from open-ended questions. Permission to conduct the study was granted by the Colorado Multiple Institutional Review Board. Appropriate consent and Health Insurance Portability and Accountability Act authorizations were obtained from study participants.

Setting

Data were collected in the emergency department, neonatal intensive care unit (NICU), and medical, surgical, neurosurgical, and burn/trauma intensive care units (adult ICUs) at the University of Colorado Hospital, a 300-bed academic hospital in Denver, Colo. Data were collected from September 1, 2003, to November 30, 2003.

Sample

A total of 202 healthcare providers responded to the survey, for an 18% overall response rate (1095 surveys mailed). Response rates were 15% for physicians, 27% for nurses, and 15% for respiratory therapists. A total of 72 members of patients' families (99% response rate) and 62 patients (95% response rate) responded to the survey. Family members and patients were approached individually, accounting for the high response rate. Family members and patients were excluded from the study if they were younger than 18 years, non–English speaking, confused, delirious, emotionally distraught, and/or incapable of decision making as assessed by a bedside nurse. In addition, patients with unstable hemodynamic status were excluded. In the NICU, only family members completed surveys. Inclusion in this study did not depend on having had prior experience with family presence.

Only 5% of nurses work in units with a written family presence protocol.

Recruitment

Names of healthcare providers were obtained from the human resources department at the University of Colorado Hospital and the office of graduate medical education at the University of Colorado at Denver and Health Sciences Center. Surveys for healthcare providers were sent through intercampus mail or were placed in unit-specific mailboxes for nurses. Surveys included preaddressed envelopes, and completed surveys were

Table 1
Selected scale items on the family presence survey

Group surveyed	Item
Healthcare providers	The family might misinterpret the activities of the healthcare providers Having the family present will help them to understand the patient's condition The family member might interfere with the care that I am providing to the patient Family presence will encourage more professional behavior from the healthcare professionals If a family member was present, the healthcare team might be more aggressive in their efforts to resuscitate the patient
Patients' family members	Being with my family member during [his or her] CPR/procedure would be too emotionally upsetting to me My family member might be cared for better by the doctors and nurses if I were with my loved one during [his or her] CPR/procedure I would want someone to go into my family member's room with me to explain what was happening during [his or her] CPR/procedure I am afraid that I would not be able to emotionally handle what was going on in my family member's room during [his or her] CPR/procedure Being with my family member during [his or her] CPR/procedure would give me peace of mind
Patients	Having my family present during my CPR/procedure will meet my emotional needs I would not want my family member with me during my CPR/procedure because [he or she] might get in the way of the care the nurses and doctors are giving me It would be important for my family to be with me during my CPR/procedure so [he or she] could see what the nurses and doctors did for me My family has a right to be with me during my CPR/procedure I would like the option of having a family member with me during my CPR/procedure

Adapted with permission from Parkland Health and Hospital System, Dallas, Tex (www.PMH.org).

Abbreviation: CPR, cardiopulmonary resuscitation.

returned to the principal investigators via intercampus mail or drop boxes placed in participating units. Patients and patients' family members present in a unit were assessed by their bedside nurses. If a patient and/or the patient's family met inclusion criteria, the nurse would ask the patient and/or family if a surveyor could speak to the patient or the family about the study. If the patient or family agreed and gave authorization, the trained nurse surveyor entered the room to discuss this study. A survey was left for the patient and/or family to complete. The completed surveys were placed in a sealed envelope and were collected from the nurses' station. The patient's and family's healthcare providers did not have access to the completed surveys.

Instruments

The surveys used in the study were adapted, with permission, from the family presence study[26] completed at Parkland Health and Hospital System, Dallas, Tex. The original Parkland survey was written in an interview format with items scored on a 4-point Likert scale. Open-ended questions were used to collect quantitative and qualitative data. The Parkland surveys were intended to explore the attitudes and beliefs of healthcare providers, patients' families, and patients who had already experienced family presence during resuscitation only. The healthcare provider survey had 47 items, the family survey had 47 items, and the patient survey had 42 items.

The instruments used in our study were adapted to collect data on participants' attitudes toward and beliefs about family presence regardless of whether the participant had previous experience with family presence. Questions and scale items were added (see Table 1 for selected sample items). The healthcare provider survey included 74 items; the family and patient surveys, 58 and 52 items, respectively.

Possible responses were strongly disagree (1), disagree (2), agree (3), and strongly agree (4). Compared with the family and patient surveys, the healthcare provider survey had items that differentiated between resuscitation and invasive procedures, a difference that accounted for the increased number of survey items on the provider survey. Although definitions of both resuscitation and invasive procedures were given on the patient and family surveys, the survey items did not differentiate between the 2 procedures.

Content validity was established through expert review by school of nursing faculty, a nurse research scientist, a pastoral care team member, physicians from the emergency department, and nurses from the emergency department, adult ICU, and NICU. Surveys were pilot tested with healthcare professionals and the lay public. The content reviewers and those piloting the survey were asked to complete the survey and comment on the length of the survey and the proposed questions. Redundant or confusing questions were removed and/or rewritten. Cronbach α values for the revised surveys used in the study were .97 for the healthcare provider survey, .93 for the family survey, and .89 for the patient survey.

Data Analysis

Data were coded, entered into SPSS, version 12 (SPSS Inc, Chicago Ill), and cleaned. Frequencies, means, and SDs were calculated. Mean scores from the scale items were summed and converted to an overall mean family presence attitude score (M-FPAS);

Table 2
Demographics of healthcare providers (n = 202)

Characteristic	Nurses: Emergency department (n = 20)	Nurses: Adult intensive care unit (n = 50)*	Nurses: Neonatal intensive care (n = 28)†	Nurses: All (n = 98)	Physicians: Attending (n = 61)†	Physicians: Nonattending‡ (n = 37)	Physicians: All (n = 98)	Respiratory therapists (n = 6)
Age, mean (SD), y	40 (10.1)	38 (9.5)	41 (10.5)	38 (9.6)	49 (10.8)	30 (3.2)	41 (12.6)	40 (7.5)
Sex, No. (%)								
Male	4 (20)	8 (17)	0 (0)	12 (13)	39 (65)	17 (46)	56 (58)	2 (33)
Female	16 (80)	40 (83)	27 (100)	83 (87)	21 (35)	20 (54)	41 (42)	4 (67)
Race, No. (%)								
White, not Hispanic	19 (95)	46 (96)	25 (89)	90 (94)	53 (87)	28 (76)	81 (83)	6 (100)
Black	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Hispanic	1 (5)	0 (0)	3 (11)	4 (4)	2 (3)	4 (11)	6 (6)	0 (0)
Asian or other Pacific Islander	0 (0)	1 (2)	0 (0)	1 (1)	2 (3)	2 (5)	4 (4)	0 (0)
Other	0 (0)	1 (2)	0 (0)	1 (1)	4 (7)	3 (8)	7 (7)	0 (0)
Years in practice, mean (SD)	10 (9.4)	13 (9.4)	16 (12)	13 (9.4)	18 (11)	3.6 (3.7)	13 (11.5)	16 (7.5)

* Sex and race data were missing in 2 cases in this group.
† Sex data were missing in 1 case in this group.
‡ Nonattending physicians are interns, residents, and fellows.

the greater the M-FPAS, the more positive the attitude toward family presence. Student's *t* tests, analysis of variance, and χ^2 tests were used to determine differences between the various groups of healthcare providers. Qualitative data were grouped into themes by using content analysis guidelines established by Munhall and Boyd.[43]

Results

Healthcare Providers

Of the 202 healthcare providers who returned a survey, 98 were nurses, 98 were physicians, and 6 were respiratory therapists. The average respondent was white (n = 177/200; 88%) and female (n = 128/198; 65%) with a mean age of 40 years (SD 11.22) and a mean of 13 years (SD 10.42) in practice (Table 2). Among the healthcare providers, 66% (n = 131/198) had previously participated in a family-witnessed resuscitation, and 86% (n = 168/195) had participated in an invasive procedure in which a patient's family member was present.

Healthcare providers had an overall positive attitude about family presence (M-FPAS 2.59, SD 0.48; Table 3). Respiratory therapists had the highest scores (M-FPAS 2.87, SD 0.75). The attitudes of care providers who were involved in a family-witnessed resuscitation (M-FPAS 2.7, SD 0.45) differed significantly from those of providers who were not (M-FPAS 2.38, SD 0.48; $P < .001$). A significant difference in attitudes also existed between those providers who were involved in a family-witnessed invasive procedure (M-FPAS 2.6, SD 0.45) and those who were not

Table 3
Mean family presence attitude scores of healthcare providers

Group	Score (SD)	t or F	P*
All nurses	2.79 (0.38)	*t* = -6.84	<.001
All physicians	2.37 (0.47)		
Nurses			
Emergency department	2.93 (0.29)	F = 2.773	.07
Adult intensive care unit	2.70 (0.39)		
Neonatal intensive care unit	2.82 (0.33)		
Physicians			
Attending	2.29 (0.47)	*t* = 2.30	.02
Nonattending†	2.51 (0.44)		

* $\alpha = .05$, 2-tailed.
† Nonattending physicians are interns, residents, and fellows.

(M-FPAS 2.3, SD 0.51; $P < .001$). Healthcare providers who support family presence during resuscitation had significantly higher scores (M-FPAS 2.4, SD 0.44) than did those who do not support the practice (M-FPAS 2.38, SD 0.48; $P < .001$). For family presence during invasive procedures, providers who support this practice also had significantly higher scores (M-FPAS 2.65, SD 0.45) than those who do not support the practice (M-FPAS 2.3, SD 0.51; $P < .001$).

Attitudes also differed significantly between nurses and physicians and between nonattending physicians (interns, residents, and fellows) and attending physicians. Nurses had more positive attitudes toward family presence than did physicians ($P < .001$). Among physicians, nonattending physicians had more positive attitudes than did attending physicians ($P = .02$). Scores

Table 4
Demographics of patients' families and patients*

Characteristic	Group: Families (n = 72)	Group: Patients (n = 62)
Age, mean (SD), y	44 (16.13)	43 (15.45)
Sex		
Male	26 (39)	30 (48)
Female	41 (61)	32 (52)
Race		
White, not Hispanic	45 (69)	44 (72)
Black	8 (12)	5 (8)
Hispanic	10 (15)	6 (10)
Asian or other Pacific Islander	1 (2)	0 (0)
Other	1 (2)	6 (10)
Marital status		
Single	14 (21)	21 (35)
Married	41 (61)	29 (49)
Divorced	5 (7)	8 (13)
Widowed	4 (6)	0 (0)
Unmarried, domestic partner	3 (4)	2 (3)
Education		
Middle school	1 (1)	0 (0)
Some high school	3 (5)	5 (8)
High school graduate/general equivalency diploma	15 (23)	12 (20)
Vocational/trade school	9 (14)	3 (5)
Some college	15 (23)	22 (36)
College graduate	16 (24)	9 (15)
Graduate school	6 (9)	9 (15)
Other	1 (2)	1 (2)

* All values are number (%) unless indicated otherwise. Because of missing data, subtotals for number of respondents do not all add up to the total number in each group. Because of rounding, percentages do not all total 100.

did not differ significantly between emergency department, ICU, and NICU nurses ($P = .02$).

The majority of healthcare providers supported family presence during resuscitation (n = 102/189, 54%) and invasive procedures (n = 127/183, 69%). Nurses favored policy development more than physicians did ($\chi^2 = 31.2$, $P < .001$), with 46% of physicians and 86% of nurses viewing a family presence protocol favorably. A total of 66% (n = 123) of healthcare providers thought that a policy on family presence was needed.

Several themes emerged from the healthcare provider qualitative data. A major concern was the safety of patients and patients' families. 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.

Another theme was concern about the emotional responses of patients' family members. Healthcare providers worried about what family members who witnessed the resuscitation "would remember about the last moments of their family member's [ie, the patient's] life." Providers also were concerned that family members might be "traumatized" by witnessing resuscitations and/or invasive procedures. Because these situations can be graphic, healthcare providers worried that family members might "freak out," causing disruption and interference with care of the patient.

In addition, healthcare providers expressed feelings of performance anxiety. In general, healthcare providers said they did "not like being watched" and became "stressed" if they were not successful. This performance anxiety, many felt, resulted in "lack of discussion among team members" when a patient's family members were present. Several healthcare providers thought that this lack of discussion would interfere with decision making and inhibit teaching if family members interpreted this discussion as an indication of incompetence. Although many mentioned performance anxiety, several healthcare providers made the comment that "as my experience level has risen, so has my comfort level [with family presence]."

The last theme was the need for an individualized approach to family presence. One provider wrote, "Situations vary depending on age of the patient, prior involvement of the family, and education of the family regarding the patient's condition." Because of the uniqueness of each situation, providers commented that "family presence should be an option, not a protocol" and that "all factors should be taken into consideration" when deciding whether a family member should be present with a patient.

Family Members

The average family member respondent was white (45/65, 69%) and female (41/67, 60%), with a mean age of 44 years (SD 16.13). A total of 24% (16/66) were college graduates, and 61% (41/67) were married (Table 4).

Family M-FPAS was 2.9 (SD 0.41). A total of 31% (20/65) previously had been present during a loved one's resuscitation or invasive procedure. The survey did not ask for details of the experience. Scores differed significantly between those family members who had previously participated in a loved one's resuscitation or invasive procedure (M-FPAS 3.06, SD 0.42) and those who had not (M-FPAS 2.9, SD 0.41; $P = .05$).

Family members felt it was their right to witness their loved one's resuscitation and/or invasive procedure and would like the option to participate. In addition, by seeing what was being done for their loved ones, family members thought they would be able to better understand the patient's condition. Among the 19 family members who had witnessed resuscitation and/or invasive procedures, 17 (89%)

said that being with their loved one was helpful to them, and 18 (95%) said that they would do the same in a similar situation. In addition, family members believed that they could control their emotions and actions and would be able to emotionally tolerate the scene.

Patients

The average patient who responded to the survey was white (44/61, 72%) and female (32/62, 52%), with a mean age of 43 years (SD 15.45). A total of 36% (22/61) had some college education and 48% (29/60) were married (Table 4). Among the patients, 29% (16/56) had previously had family present during a resuscitation or an invasive procedure. The survey did not ask for details of the experience.

Patient M-FPAS was 2.65 (SD 0.45). Scores did not differ significantly between those patients who had previously had family present during their resuscitation or invasive procedure. Like family members, patients felt that it was their right to have a family member present and that the option of family presence should be extended to them. Patients felt it would be comforting to have family members present.

Because few open-ended questions were answered by family members and patients, content analysis was not performed on the scant qualitative data that was generated.

Discussion

Our results add to the growing body of literature that indicates that healthcare providers, patients' families, and patients have positive attitudes toward family presence and that nurses have a more favorable attitude toward family presence than do physicians.[21,25-28] However, in our study the nonattending physicians had a more favorable attitude toward family presence than did attending physicians, a finding that differs from previous results reported in the literature.[26] These differences may be attributed to recent trends in which family involvement is more prevalent in the hospital training environment. Studies[25,27,28] on whether or not the option of family presence should be extended to patients' family members also indicated that nurses were more open to the practice of family presence then were physicians.

Although attitude scores did not differ significantly between emergency department, adult ICU, and NICU nurses, NICU nurses had more positive attitudes. At the University of Colorado Hospital, family presence is a well-established practice in the NICU, probably accounting for the more favorable attitudes among the NICU nurses. Emergency department nurses had more positive attitudes toward family presence than did adult ICU nurses. Because family members often bring patients to the emergency department, the family members are often part of the treatment process. Emergency department nurses may therefore be more accustomed to including families in the care environment.

Healthcare providers indicated they had several concerns about family presence. Concerns about the safety of patients and their families have been cited as a potential barrier to family presence.[25,27,28,44] However, data do not support these concerns, and some healthcare providers thought that family presence helped both patients and patients' family members and that the family members acted appropriately during the event.[26] In addition, family members and patients understood that family presence was only an option if the family member did not interfere with care, and some family members actually moved away from the patient's bedside if they became too emotionally distraught.[26,42,45] These findings suggest that patients and families not only understand their limitations but are able to determine when family presence may be inappropriate.

Concern about the emotional well-being of patients' family members is another barrier to family presence.[25,26,29] Although healthcare providers worry about the emotional impact on patients' families, families reported no untoward effects.[26] In a study of the psychological effects of being present at a family member's resuscitation, Robinson et al[41] found no psychological trauma in family members. In our study, family members thought that they could emotionally tolerate a family presence event, and 31% had experienced family presence. It is unclear if the family members who had not experienced family presence would feel the same as those who had.

Seventy-four percent of families believed they benefited their dying loved one by being present.

Healthcare providers in our study cited performance anxiety as a potential barrier to family presence, a concern reported in other studies. This concern is understandable because of the nature of the academic teaching environment and the relative inexperience of the healthcare providers.[27,28]

In our study, healthcare providers emphasized that family presence should be an option because situations are so variable. Most providers thought that a policy should be in place to ensure that guidelines are consistently followed during a family presence episode. Consistent with other findings,[8] nurses in our study favored policy development more than physicians did.

Many of the family members and patients in our study had prior experience with family presence, a situation that might have influenced their positive attitude toward family presence. In keeping with the findings in other studies,[27,39,40,46] the family members and patients in our study thought that family presence was their right and said that they would like to have the option to have family members present during resuscitation and/or invasive procedures. Other investigators[26,39] found that being present at the bedside helped family members understand the seriousness of a patient's condition, facilitated grieving, and showed the family that healthcare providers did everything possible to help the patient. Our finding that family members who had witnessed resuscitation and/or invasive procedures thought being present was helpful for themselves and their loved ones is consistent with the findings of other studies.[18,26]

As family presence becomes a more accepted practice, healthcare providers will need to accommodate families at the bedside and address the barriers that impede the practice.

Strengths and Limitations

The survey instrument we used was reliable and valid. The response rate of healthcare providers was low, and qualitative data from families and patients were minimal. The study may have nonrespondent bias because of the length of the survey and/or because only those who were interested in the subject completed the survey. Furthermore, our sample lacked ethnic diversity.

Patients felt it was their right to have a family member present and that the option of family presence should be extended to them.

Recommendations

We recommend that family presence be studied in nonacademic hospitals and in other medical-surgical units and specialty areas to allow for more generalizability of the findings. In addition, surveying an ethnically diverse population would increase generalizability and help determine whether culture plays a role in the desire for family presence. Solicitation of patients' and families' beliefs about and attitudes toward family presence could be facilitated by conducting interviews or using focus groups. A shorter survey, one that includes scale items and only a few open-ended questions, might be sufficient to collect data from healthcare providers. A shorter survey might increase the response rate of healthcare providers. We also recommend evaluation of current family presence protocols and their effects on healthcare providers, patients' families, and patients.

Conclusion

On the basis of these and other findings, family presence clearly is becoming a more acceptable practice. Family presence may benefit both patients and patients' families. Although perceived and real barriers remain, creating a hospital policy for family presence that addresses healthcare providers' concerns and offers support for the practice is important. With a multidisciplinary approach and recognition of the uniqueness of each care situation, family presence can be effectively and safely implemented.

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FINANCIAL DISCLOSURES
None reported.

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REFERENCES

1. Henneman EA, Cardin S. Family-centered care: a practical approach to making it happen. *Crit Care Nurse*. December 2002;22:12-16, 18-19.
2. Leske JS. Needs of adult family members after critical illness: prescriptions for interventions. *Crit Care Nurs Clin North Am*. 1992;4:587-596.
3. Berns R, Colvin ER. The final story: events at the bedside of dying patients as told by survivors. *ANNA J*. 1998;25:583-587.
4. Molter NC. Needs of relatives of critically ill patients: a descriptive study. *Heart Lung*. 1979;8:332-339.
5. Bauchner H, Waring C, Vinci R. Parental presence during procedures in an emergency room: results from 50 observations. *Pediatrics*. 1991;87:544-548.
6. Boie ET, Moore GP, Brummett C, Nelson DR. Do parents want to be present during invasive procedures performed on their children in the emergency department? A survey of 400 parents. *Ann Emerg Med*. 1999;34:70-74.
7. Haimi-Cohen Y, Amir J, Harel L, Straussberg R, Varsano Y. Parental presence during lumbar puncture: anxiety and attitude toward the procedure. *Clin Pediatr*. 1996;35:2-4.
8. Mangurten JA, Scott SH, Guzzetta CE, et al. Family presence: making room. *Am J Nurs*. May 2005;105:40-48.
9. Powers KS, Rubenstein JS. Family presence during invasive procedures in the pediatric intensive care unit: a prospective study. *Arch Pediatr Adolesc Med*. 1999;153:955-958.
10. Wolfram RW, Turner ED. Effects of parental presence during children's venipuncture. *Acad Emerg Med*. 1996;3:58-64.
11. Beckman AW, Sloan BK, Moore GP, et al. Should parents be present during emergency department procedures on children, and who should make that decision? A survey of

emergency physician and nurse attitudes [published correction appears in *Acad Emerg Med*. 2002;9:287]. *Acad Emerg Med.* 2005;9:154-158.
12. Fein JA, Ganesti J, Alpern ER. Medical staff attitudes toward family presence during procedures. *Pediatr Emerg Care*. 2004;20:224-227.
13. O'Brien M, Creamer K, Hill E, Welham J. Tolerance of family presence during pediatric cardiopulmonary resuscitation: a snapshot of military and civilian pediatricians, nurses, and residents. *Pediatr Emerg Care*. 2002;18:409-413.
14. Sacchetti A, Lichenstein R, Carraccio CA, Harris RH. Family member presence during pediatric emergency department procedures. *Pediatr Emerg Care*. 1996;12:268-271.
15. Sacchetti A, Carraccio C, Leva E, Harris RH, Lichenstein R. Acceptance of family member presence during pediatric resuscitations in the emergency department: effects of personal experience. *Pediatr Emerg Care*. 2000;16:85-87.
16. Sacchetti A, Paston C, Carraccio C. Family members do not disrupt care when present during invasive procedures. *Acad Emerg Med*. 2005;12:477-479.
17. Byrd T. Family presence during CPR: a case presentation. *Nurs Spectr (Gt Phila Tri State Ed).* 2001;10:14.
18. Eichhorn DJ, Meyers TA, Mitchell TG, Guzzetta CE. Opening the doors: family presence during resuscitation. *J Cardiovasc Nurs*. 1996;10:59-70.
19. Hanson C, Strawser D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine year perspective. *J Emerg Nurs*. 1992;18:104-106.
20. Petterson M. Family presence protocol can be a powerful healing force. *Crit Care Nurse*. December 1999;19:104.
21. Post H. Letting the family in during a code. *Nursing*. March 1989;19:43-46.
22. Rosenczweig C. Should relatives witness resuscitation? Ethical issues and practical considerations. *CMAJ*. 1998;158:617-620.
23. Vanderbeek J. Till death do us part: a firsthand account of family presence. *Am J Nurs*. February 2000;100:44.
24. Timmermans S. High touch in high tech: the presence of relatives and friends during resuscitative efforts. *Sch Inq Nurs Pract*. 1997;11:153-173.
25. Redley B, Hood K. Staff attitudes toward family presence during resuscitation. *Accid Emerg Nurs*. 1996;4:145-151.
26. Meyers TA, Eichhorn DJ, Guzzetta CE, et al. Family presence during invasive procedures and resuscitation. *Am J Nurs.* February 2000;100:32-43.
27. Helmer SD, Smith SR, Dort JM, Shapiro WM, Katan BS. Family presence during trauma resuscitation: a survey of AAST and ENA members. American Association for the Surgery of Trauma. Emergency Nurses Association. *J Trauma*. 2000;48:1015-1024.
28. McClenathan BM, Torrington KG, Uyehara CF. Family member presence during cardiopulmonary resuscitation: a survey of US and international critical care professionals. *Chest*. 2002;122:2204-2211.
29. MacLean SL, Guzzetta CE, White C, et al. Family presence during cardiopulmonary resuscitation and invasive procedures: practices of critical care and emergency nurses. *Am J Crit Care*. 2003;12:246-257.
30. American Nurses Association. *Code of Ethics for Nurses With Interpretive Statements*. Silver Spring, Md: American Nurses Association; 2000.
31. Emergency Nurses Association. Position statement: family presence at the bedside during invasive procedures and cardiopulmonary resuscitation. October 2005. Available at: http://www.ena.org/about/position/. Accessed February 2, 2007.
32. Emergency Nurses Association. *Trauma Nursing Core Course*. 5th ed. Des Plaines, Ill: Emergency Nurses Association; 2000.
33. Emergency Nurses Association. *Emergency Nursing Pediatric Course*. 2nd ed. Park Ridge, Ill: Emergency Nurses Association; 1998.
34. Emergency Nurses Association. *Presenting the Option for Family Presence*. 2nd ed. Bedford Park, Ill: Emergency Nurses Association; 2001.
35. American Association of Critical-Care Nurses. Practice alert: family presence during CPR and invasive procedures. 2004. Available at: http://www.aacn.org/AACN/practiceAlert.nsf/vwdoc/pa2. Accessed February 2, 2007.
36. National Association of Emergency Medical Technicians. Guidelines for providing family-centered pre-hospital care. 2000. Available at: http://www.naemt.org/divisionsAndCommittees/pediatricCommittee/emsc.htm. Accessed February 19, 2007.
37. National Association of Social Workers. Bereavement practice guidelines for health care professionals in the emergency department. 1999. Available at: http://www.nedarc.org/nedarc/emscProducts/EP000822.pdf. Accessed February 19, 2007.
38. Cummins RO, Hazinski M. Most important changes in the International ECC and CPR Guidelines 2000. *Circulation.* 2000;102(8 suppl):I371-I376.
39. Doyle CJ, Post H, Burney RE, Maino J, Keefe M, Rhee KJ. Family participation during resuscitation: an option. *Ann Emerg Med*. 1987;16:673-675.
40. Meyers TA, Eichhorn DJ, Guzzetta CE. Do families want to be present during CPR? A retrospective survey. *J Emerg Nurs*. 1998;24:400-405.
41. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, Egleston CV, Prevost AT. Psychological effects of witnessed resuscitation on bereaved relatives. *Lancet*. 1998;352:614-617.
42. Eichhorn DJ, Meyers TA, Guzzetta CE, et al. Family presence during invasive procedures and resuscitation: hearing the voice of the patient. *Am J Nurs*. May 2001;101:48-53.
43. Munhall PL, Boyd CO. *Nursing Research: A Qualitative Perspective*. 2nd ed. New York, NY: National League for Nursing; 1998.
44. Belanger MA, Reed S. A rural community hospital's experience with family-witnessed resuscitation. *J Emerg Nurs*. 1997;23:238-239.
45. Morse JM, Pooler C. Patient-family-nurse interactions in the trauma-resuscitation room. *Am J Crit Care*. 2002;11:240-249.
46. Barratt F, Wallis DN. Relatives in the resuscitation room: their point of view. *J Emerg Accid Med*. 1998;15:109-111.

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CE Test **Test ID A0716033: Attitudes Toward and Beliefs About Family Presence: A Survey of Healthcare Providers, Patients' Families, and Patients.** *Learning objectives:* 1. Discuss current attitudes about family presence during resuscitation and/or invasive procedures. 2. Review the current literature concerning family presence related to both healthcare providers and patients and patients' families. 3. Describe family presence survey results, conclusions, and recommendations.

1. Family presence is defined as which of the following?
a. Attendance of the patient's visitors during resuscitation of the patient
b. Attendance of the patient's family members during resuscitation and/or invasive procedures
c. Attendance of the patient's visitors during resuscitation and/or invasive procedures
d. Attendance of the patient's visitors during invasive procedures

2. What kind of an approach to care is family-centered care?
a. When visitors to the patient are not restricted to family members
b. When care is provided for the patient in a room with an attached family room
c. When care is provided for the patient with family involvement
d. When care is provided for patients and their families

3. The study by Meyers and colleagues was the first to use the family presence protocol developed by the Emergency Nurses Association (ENA) to study the experiences of healthcare providers and patients' families. What were the results of that study?
a. Positive attitudes toward family presence
b. Residents had more positive attitudes toward family presence
c. Nursing staff had more positive attitudes than did families
d. Attending physicians had more positive attitudes than did nurses

4. What percentage of the 343 professionals who had experienced family presence surveyed by McClenathan and colleagues at a critical care conference would allow family presence again?
a. 61%
b. 36%
c. 40%
d. 45%

5. Which of the following organizations supports an option of family presence?
a. ENA and the American Medical Society
b. ENA and the American Association of Critical-Care Nurses (AACN)
c. AACN and the American Medical Society
d. AACN and the Association of Operating Room Nurses

6. Which of the following were results of the family presence opinion survey of patients and patients' families by Doyle and colleagues?
a. 72% thought they were well informed about what to expect during resuscitation
b. 70% thought that adjustment to death and grieving was made easier by being present
c. 61% felt that the staff communicated with them clearly
d. 76% talked with their loved one

7. Which of the following gathered the first data on patients' attitudes and beliefs after the patients' families had been present during resuscitation and/or invasive procedures?
a. Meyers and colleagues
b. Helmer and colleagues
c. Eichhorn and colleagues
d. Doyle and colleagues

8. What type of survey design was used to generate quantitative and qualitative comments from open-ended questions in this study?
a. Limited to those who had experienced family presence
b. Limited to healthcare workers who had experienced family presence
c. Descriptive
d. Descriptive with bias

9. Because inclusion in this study did not depend on having prior experience with family presence, what percentage of healthcare providers had participated in a family-witnessed resuscitation?
a. 66%
b. 76%
c. 56%
d. 67%

10. What percentage of family members answering the study survey had been present during a loved one's resuscitation/invasive procedure?
a. 31%
b. 35%
c. 60%
d. 61%

11. Study recommendations indicated that which of the following might increase the response rate of healthcare providers?
a. Individual approach like the approach taken with families
b. Designated time to fill out the survey questions
c. Scaled items instead of open-ended questions
d. Shorter surveys with scaled items and open-ended questions

Test Answers: Mark only one box for your answer to each question. You may photocopy this form.

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EBR Evidence-Based Review

Evidence-Based Review and Discussion Points

By Ruth Kleinpell, RN, PhD

Evidence-Based Review (EBR) is the journal club feature in the *American Journal of Critical Care.* In a journal club, attendees review and critique published research articles: an important first step toward integrating evidence-based practice into patient care. General and specific questions such as those outlined in the "Discussion Points" box aid journal club participants in probing the quality of the research study, the appropriateness of the study design and methods, the validity of the conclusions, and the implications of the article for clinical practice. When critically appraising this issue's EBR article, found on pp 270-279, consider the questions and discussion points outlined in the "Discussion Points" box. Visit **www.ajcconline.org** to discuss the article online.

The topic of family presence has distinct application for patients in high acuity and critical care settings. The purpose of this study, "Attitudes Toward and Beliefs About Family Presence: A Survey of Healthcare Providers, Patients' Families, and Patients," by Duran and colleagues, was to describe and compare clinicians', patients', and families' beliefs and attitudes regarding family presence during resuscitation and/or invasive procedures.

Investigator Spotlight

This feature briefly describes the personal journey and background story of the EBR article's lead investigator, discussing the circumstances that led him or her to undertake the line of inquiry represented in the research article featured in this issue.

Christine Duran

What led these investigators to conduct their research on family presence in the intensive care unit (ICU)? Christine Duran explains that it was her coinvestigator, Kathleen Oman, RN, PhD, CNS, from the division of Professional Resources at the University of Colorado Hospital, who encouraged her to pursue their mutual interest in the issue. "There had been interest in performing a study like ours," says Duran, "but other projects took precedence for some time. I was actually interested in the subject as a new ICU nurse, and Kathy suggested that I take on the project. In fact, she was quite excited that the topic would be revisited. We then proceeded to put a multidisciplinary team together to work on it."

Oman and Duran are conducting additional research along the same lines as those in this study. "We implemented a family presence policy last fall," says Duran. "Now we are in the process of surveying healthcare providers. We want to explore whether attitudes about family presence have changed and examine things we can do to improve the experience for everyone involved. In addition, the hospital medical board, though supportive of the overall practice of having family members present during CPR and/or invasive procedures, wants to see follow-up data since implementation of the policy."

In Duran's view, readers of the *American Journal of Critical Care* can best use the information in this issue's EBR source article to help support the practice of family presence as well as to advocate for family presence where they work. "I would like readers to use the data to add to the arsenal of evidence supporting family presence," she notes. "I hope that the more research that is out there, the easier it will be to implement the practice in other hospitals. I hope this article encourages providers in other hospitals to write their own policies on family presence, or at least to open up the discussion about family presence with colleagues."

Study Synopsis

A descriptive survey methodology was used to assess clinician, family member, and patient perceptions in several settings in an academic hospital including the emergency department and adult and neonatal intensive care units (ICUs). A total of 202 clinicians, 72 family members, and 62 patients completed a survey that was adapted from previous research conducted on family presence.

The survey generated both quantitative and qualitative data. The study results revealed that clinicians, family members, and patients had positive attitudes about family presence. Respiratory therapists had the highest scores on the survey, indicating favorable attitudes, and nurses had more favorable attitudes toward family presence than did physicians. Most healthcare providers supported family presence during resuscitation (54%) and invasive procedures (69%). Clinicians indicated some concerns about safety, the emotional response of the family, and performance anxiety. This study serves to extend the evidence base on the use of family presence, especially as it relates to attitudes and beliefs about family presence.

Information From the Authors

Christine Duran, APRN-BC, DNP, CNS, CCTN, lead author of this EBR article, provided additional information about the study. She explains that the survey was distributed to hospital staff via the interhospital

mail system. The survey was completed by a large number of healthcare providers in the institution. She notes that "we did not do a second mailing as it was too costly and we had no funding. We did have people on our research team remind staff to complete surveys."

Enlisting the participation of family members in the study required a team effort. Dr Duran explains: "Consistent with HIPAA [Health Insurance Portablity and Accountability Act] regulations, the bedside nurse taking care of the patient and family approached the subjects initially. The nurse asked the patient and family if we [the investigators] could speak with them about a study we were conducting. If the patient and family agreed, the investigators then went in, explained the study, and asked if the patient and family would like to take the survey."

The response rate to the survey was good owing to several strategies. Dr Duran explains: "We had such a good response rate because we were able to approach each patient and family individually. The initial approach by the bedside nurse was not considered part of the response rate because they did not actually hand out the survey; they simply asked if an investigator could come to speak with them about the study. If we based response rate on the RN approach, we would have had a poorer response rate."

Inclusion in the study was not dependent on having had prior experience with family presence. However, Dr Duran notes that clinicians who had previous experience did express more positive attitudes toward family presence. "There was a significant difference in attitudes among those care providers who had been involved when a family witnessed resuscitation compared to those who had not," she says. "A significant difference in attitudes also was found between those providers who had been involved with a family witnessing invasive procedures and those who had not.

"Providers had a more positive attitude if they already had been involved in a family presence situation. There also was a significant difference among family members who previously had participated in a loved one's resuscitation or invasive procedure versus those who had not. However, there was not a significant difference between those patients who previously had had family members present during their resuscitation or invasive procedure."

About the Author

Ruth Kleinpell is contributing editor of the Evidence-Based Review section. She is a professor in the Rush University College of Nursing, a teacher-practitioner at the Rush University Medical Center, and a nurse practitioner with Our Lady of the Resurrection Medical Center, Chicago, Ill.

Implications for Practice

According to the study results, clinicians, family members, and patients had positive attitudes about family presence. Dr Duran adds: "I think the results show that patients and families at least want the option, and it seems that most providers are willing to give it a try. We need to be leaders not only in the area of family presence, but in patient- and family-centered care as well. As nurses in acute and critical care settings, we need to continue to advocate for family presence."

eLetters

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Discussion Points

A. Description of the Study

- ❑ What was the purpose of the research?
- ❑ Why is the problem significant for those working in critical and high acuity care?

B. Literature Evaluation

- ❑ What previous research on family presence has been conducted?
- ❑ Where are there gaps in the research evidence on the use of family presence?

C. Sample

- ❑ What were the study's inclusion and exclusion criteria?

D. Methods and Design

- ❑ How were the data collected?
- ❑ What measures were used to assess the soundness of the survey instrument, which was adapted from previous research on the topic of family presence?

E. Results

- ❑ What were the findings of the research?
- ❑ What themes emerged from the qualitative data?

F. Clinical Significance

- ❑ What are the implications of this study for clinical practice?
- ❑ How does the study extend the evidence base for family presence during resuscitation and invasive procedures?