

FAMILY PRESENCE: EVIDENCE VERSUS TRADITION

By Diana J. Mason, RN, PhD, Editor in Chief, *American Journal of Nursing*.

Once was traumatized during a pediatric cardiac arrest . . .,” said a nurse, “where the father witnessed the arrest [of his daughter] and was not allowed in during CPR. He asked repeatedly to come in and ‘say goodbye’ while she was still alive. He wanted to hold her hand. Not only was he kept from the room, but security was called to keep him out. The child did not survive. She was 6. . . . He just wanted to be with her when she died, and we took that away from him.”¹

This statement was made by a nurse surveyed about “family presence,” the practice of allowing patients’ family members to be present during invasive procedures or cardiopulmonary resuscitation (CPR). The full results of the survey are reported in this issue of the journal.¹ The nurse’s comments, and the survey’s findings in general, make powerful statements that run counter to the rhetoric that became fashionable in the 1990s in support of patient- and family-centered care.

Family presence has been a controversial issue in the past decade. In 1992, Foote Hospital reported a positive experience with family presence in the emergency department.² Subsequently, several researchers published either anecdotal reports of experiences with family presence³⁻⁵ or reports of the attitudes of family members and healthcare staff toward the practice (either retrospectively or hypothetically).⁶⁻¹¹ In response to continued skepticism about the practice, in 2000 Meyers et al¹² and Eichhorn et al¹³ published the results of their prospective study of the responses of healthcare providers, patients’ families, and patients to family presence in the emergency department of Parkland Memorial Hospital in Dallas, Tex. Although approximately one third of patients’ family members did not want to participate in family presence, 100% of those who did participate said they would make the same choice again, and almost all said they thought it was their right to be present. Among healthcare providers, medical residents were the most uncomfortable with having patients’ family members present during inva-

sive procedures and CPR, but nurses and attending physicians overwhelmingly supported the practice after they experienced it. Patients stated that they benefited from having their families present, although they expressed concern about its emotional impact on family members.

Despite a growing movement in support of family presence, many physicians and others in healthcare continue to resist adopting the practice. Major arguments against it include the following:

- Not enough research supports making a change in practice. The truth is that no evidence supports the tradition of keeping patients’ family members out of the room during invasive procedures. Also, more than 10 years of research indicate that patients, healthcare providers, and patients’ family members find family presence beneficial. The only significant data against the practice come from surveys^{11,14} of physicians’ attitudes toward family presence, which indicate that most physicians oppose the practice. However, exposure to a well-designed approach to family presence can change physicians’ opinions. Physicians at Parkland Hospital who participated in the study by Meyers et al¹² became supporters of family presence and subsequently backed the hospital’s adoption of a written policy permitting the practice.

- Family presence will increase the number of malpractice lawsuits. On the contrary, providers at Foote Hospital, Parkland Hospital, and other hospitals say that the number does not increase. Family presence allows the development of a strong bond between patients’ family members and healthcare staff, making lawsuits unlikely. In the study by Meyers et al,¹² family members said they were able to see that staff did everything that could be done to help the families’ loved ones.

- Nurses and physicians cannot agree on the issue. Helmer et al¹¹ found that nurses were more supportive of family presence than were physicians who had not experienced it; the authors concluded that changes in policy should not be made until nurses and physicians are in agreement. Educating physicians, nurses, administrators, and others about the practice is the key. In 1993, the Emergency Nurses Association

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(ENA) adopted a resolution to support family presence and later developed a protocol for implementing the practice within institutions.¹⁵ Revised in 2001, this protocol should be used in all institutions.¹⁶

- Having a patient's family members present during CPR or invasive procedures will make the healthcare staff nervous, a situation that could be detrimental to the patient. An experienced orthopedic surgeon who felt this way also noted that no studies have examined how the presence or absence of patients' family members affects clinical outcomes. However, it is now almost routine for family members to be asked to stay with a child during certain procedures. Why? Because unlike adults, children often complain loudly when their parents are outside the room; furthermore, clinicians (physicians included) realize that parents can be of help in supporting children. Although research on the effects of family presence on clinical outcomes would be interesting, no compelling evidence indicates that the practice should be halted until such research is done.

- Not enough is known about the psychosocial impact of family presence. One nurse researcher told me that her mother-in-law was quite traumatized by witnessing CPR performed on her father-in-law after trauma. But no harmful effects were found in the only randomized clinical trial⁸ that examined the psychological impact, and the researchers stopped the study because of what they perceived to be only beneficial effects. This finding does not mean that some persons are not traumatized by what they witness. But why deny patients' family members the option to be in the room—especially when existing data indicate that family members are not harmed by the practice?^{8,12} Undoubtedly, institutions should be guided by the ENA protocols.¹⁶ The protocols recommend screening patients' family members; providing support to the family members before, during, and after the experience; keeping family presence as an invitation to family members rather than an expectation of the family; and actively supporting family members in their refusal to participate.

- Family presence violates patients' privacy. This argument against family presence is posed for CPR and procedures done on unconscious patients. McClenathan et al¹⁴ recommend that this situation be addressed in advance directives. In light of the positive responses of patients to having family members present, why not err on the side of providing what most patients and their families consider a right?

When the studies of Meyers et al¹² and Eichhorn et al¹³ were first published, the findings were disseminated to journalists. The reports received wide atten-

tion in the media, including coverage by CNN, ABC World News Tonight, The View, *The New York Times*, *Los Angeles Times*, *Washington Post*, *Newsweek*, and local television and radio stations. Many of the journalists asked for the name of a local institution that permitted family presence. I tried to identify such institutions. I heard repeatedly that individual nurses would admit patients' family members during CPR and invasive procedures without institutional sanction. Invariably, I referred journalists to a handful of hospitals that had been practicing family presence under written policies and procedures without incident. (I found no hospital that had tried and then discontinued the practice.)

The study reported by MacLean et al¹ reflects the interest in determining the prevalence of family presence as a formally sanctioned or unsanctioned practice among critical care and emergency nurses. These authors¹ found that a majority of nurses had either taken patients' family members into the patients' rooms during CPR or invasive procedures or would do so if the opportunity arose. And yet only 5% of the nurses said that their institutions had written policies permitting family presence (1% had policies against the practice). And when asked whether policies should be written or unwritten, more respondents preferred that the policies be unwritten. Why? Did the respondents think that if they failed at formalizing family presence they would no longer be able to do it?

Patients' family members are asking to be with the patients during invasive procedures. Shouldn't nurses ensure that institutions honor these requests when staffing allows? If a unit or an institution allows family presence without a formal policy, why not formalize the practice and ensure that the ENA guidelines are followed? Family presence should not be taken lightly. It deserves careful attention and handling.

It is time for nurses to challenge their institutions to adopt written policies and procedures to allow family presence. Eichhorn et al¹⁷ have written about the politics of getting institutions to adopt family presence. The ENA has slides and handouts available to help in formal and informal education within institutions. In addition, national organizations of nurses and physicians can endorse family presence.

Supporting family presence now does not preclude the need for ongoing research to better understand the practice. But we lack research indicating that we are not harming patients, healthcare providers, and patients' family members when the security staff are called to forcibly remove parents from the bedside of a dying child. So, let's act on the available research and make family presence an option for families nationwide.

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