

Provider Experience and Attitudes toward Family Presence during Resuscitation Procedures

Dear Editor:

In recent years, there has been growing interest in extending palliative care beyond traditional settings (i.e., hospices, nursing and private homes) to other areas of medicine, including emergency care.¹ Family presence during critical resuscitation provides a compelling example of this movement and represents an opportunity for a palliative care intervention in the setting of the acute management of a critical patient. Family presence is an area of ongoing debate among emergency care providers. We report here results of a survey study that provides greater insight into this controversy.

Previous studies suggest that family presence has a positive impact on family members, easing their grief response without apparent negative sequelae.²⁻⁷ By contrast, studies assessing clinicians' attitudes toward family presence have revealed concerns with this practice.^{2,4,8-11} There is some indication that prior experience with family presence influences providers' attitudes toward this practice.¹²⁻¹⁵ Our study intended to investigate this relationship, as well as to explore demographic factors that may predict provider support across different types of resuscitation events.

We surveyed all 210 emergency department attendings, residents, nurses, and technicians at the University of Michigan, a large academic teaching hospital (response rate, 78.1%). The questionnaire assessed providers' prior experience with family presence in the emergency department, as well as their support for and attitudes toward this practice. It addressed different types of resuscitations (i.e., medical versus traumatic and adult versus pediatric) and provided a clear definition of family presence (i.e., the option for a maximum of two family members to witness a resuscitation after screening by social work, who would subsequently accompany the family).

The demographic information for our respondents is outlined in Table 1. A majority of providers expressed support for family presence across all resuscitation types (Table 2). Logistic regression analysis

indicated that provider support for family presence correlated strongly with self-reported prior experience (Table 3), but was not predicted by age, gender, years in practice, or provider group. Although we found a trend indicating that technicians are the least supportive of family presence among the provider groups, these results were not statistically significant. Table 4 indicates the proportion of respondents who expressed agreement with views about how family presence impacts family members, patient care, and providers.

Our critical finding is that self-reported prior experience with family presence is a strong predictor of provider support. Across all resuscitation types, prior experience was the only significant predictor of support for family presence when controlling for varied demographic factors. We believe these results carry important implications with regard to the future development and implementation of family presence policies. Anecdotes and testimonies from practitioners would suggest that experiencing family presence allows providers to witness the benefits to family members and alleviates concerns that there will be negative consequences. Thus, staff training and event simulation may be helpful in promoting provider comfort with family presence. Our findings further indicate that emergency providers are most concerned about an increase in team stress and the difficulties of teaching trainees while family members are present. Staff training must specifically address these issues be-

TABLE 1. SAMPLE DEMOGRAPHICS

Age, avg. years	37.5
Gender, % female	55.2
Years in practice, avg. years	8.3
Provider subgroups:	
Total count	178
Technicians	36
Nurses	88
EM residents	29
EM attendings	25

EM, emergency medicine.

TABLE 2. PROVIDER SUPPORT FOR FAMILY PRESENCE BY RESUSCITATION TYPE

	<i>Proportion (%)</i>
Adult medical	76.6
Adult trauma	65.1
Pediatric medical	69.5
Pediatric trauma	62.2

Note: Neutral responses were grouped with those who indicated that they were not supportive, since subsequent analysis intended to look for predictors of support for family presence.

TABLE 3. PROVIDER EXPERIENCE IMPACTS SUPPORT FOR FAMILY PRESENCE

	<i>Odds ratio^a</i>	<i>95% CI</i>
Adult medical	4.5	1.8–11.4
Adult trauma	2.2	1.1–4.5
Pediatric medical	4.7	2.1–10.3
Pediatric trauma	4.2	2.0–9.1

^aThe odds ratios reflect the relative likelihood of support for family presence given self-reported experience with family presence. Our regression analysis controlled for age, gender, years in practice, and provider group.
CI, confidence interval.

TABLE 4. PROVIDER ATTITUDES TOWARD FAMILY PRESENCE

	<i>Total proportion (%)</i>	<i>Techs (36)</i>	<i>Nurses (88)</i>	<i>EM residents (29)</i>	<i>EM attendings (25)</i>
Benefit to family	77	53	85	79	84
Excessive stress for family	29	42	31	17	24
Prolong heroic efforts	42	47	41	34	40
Interfere with patient care	21	33	20	14	16
Excessive stress for team	45	53	38	55	48
Greater malpractice risk	13	19	15	0	12
Distracting to team	29	42	30	28	16
Difficult to teach trainees	52	67	44	62	48

EM, emergency medicine.

fore family presence policies can be successfully implemented in teaching hospitals.

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