

## Deciding “case by case” on family presence in the emergency care service

Decidindo “caso a caso” a presença familiar no serviço de atendimento emergencial

Decidiendo “caso por caso” la presencia familiar en el servicio de atención de urgencias

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### Abstract

**Objective:** To understand how physicians and nurses experience and perceive the presence of families in the emergency care service.

**Methods:** This was a qualitative study that used symbolic interactionism as a theoretical reference, and grounded theory as a methodological reference. Twenty professionals participated – equally representing physicians and nurses - working in two emergency rooms located in the south of Brazil. Data were collected between October of 2016 and February of 2017, by means of interviews.

**Results:** The existence of a social culture of family exclusion was identified, widely diffused and practiced by professionals. However, families sometimes remain with their loved ones in the emergency room, since professionals analyze and decide “case by case”, considering different aspects throughout the care process.

**Conclusion:** Multiple aspects are related in determining family presence during emergency care for physicians and nurses. Thus, a single directive on the presence of the family is not prudent. In fact, it is suggested that each health unit develop its protocols, considering local particularities.

### Resumo

**Objetivo:** Compreender como médicos e enfermeiros vivenciam e percebem a presença da família no serviço de atendimento emergencial.

**Métodos:** Estudo qualitativo que utilizou o Interacionismo Simbólico como referencial teórico e a Teoria Fundamentada nos Dados como referencial metodológico. Participaram 20 profissionais – divididos equitativamente entre médicos e enfermeiros – que atuavam em duas Salas de Emergência localizadas no Sul do Brasil. Os dados foram coletados entre outubro de 2016 e fevereiro de 2017, por meio de entrevistas.

**Resultados:** Identificou-se a existência de uma cultura social de exclusão familiar, amplamente difundida e praticada pelos profissionais. Contudo, às vezes, as famílias permanecem com seus entes queridos na Sala de Emergência, visto que os profissionais analisam e decidem “caso a caso”, considerando diferentes aspectos ao longo do processo assistencial.

**Conclusão:** Para médicos e enfermeiros múltiplos aspectos estão relacionados na determinação da presença familiar durante o atendimento emergencial. Assim, não é aconselhável uma diretiva única para a presença da família. Em realidade, sugere-se que cada unidade de saúde elabore seus protocolos considerando as particularidades locais.

### Resumen

**Objetivo:** Comprender cómo médicos y enfermeros experimentan y perciben la presencia familiar en el servicio de atención de urgencias.

**Métodos:** Estudio cualitativo, aplicando el Interaccionismo Simbólico como referencial teórico, y la Teoría Fundamentada en los Datos como referencial metodológico. Participaron 20 profesionales –equitativamente divididos entre médicos y enfermeros– actuantes en dos Servicios de Urgencias del Sur de Brasil. Datos recolectados de octubre 2016 a febrero 2017 mediante entrevistas.

**Resultados:** Se identificó la existencia de una cultura social de exclusión familiar, ampliamente difundida y practicada por los profesionales. Igualmente, a veces, las familias permanecen con sus seres queridos en el Servicio de Urgencias, dado que los profesionales analizan y deciden “caso por caso”, considerando diferentes aspectos a lo largo del proceso de atención.

**Conclusión:** Para médicos y enfermeros, múltiples aspectos se relacionan con la determinación de la presencia familiar durante la atención de urgencia. Por ello, no es aconsejable una directiva única sobre presencia familiar. En realidad, se sugiere que cada unidad de salud elabore sus protocolos considerando sus propias características.

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## Introduction

The presence of the family in emergency care, during invasive procedures - including maneuvers of cardio-pulmonary resuscitation - has been studied in several parts of the world.<sup>(1-5)</sup> However, despite the scientific evidence suggesting that this presence is positive for professionals, family and patients,<sup>(6,7)</sup> and, with the endorsement and encouragement of scientific critical care societies increasing, health professionals continue to strongly oppose this practice.<sup>(2)</sup>

Sometimes, the presence of the family is not allowed because the professionals fear that the relatives will: be impacted by the scenes occurring in the emergency service; interfere with the performance of procedures; prosecute institutions and professionals for misinterpreting clinical decisions; breach confidentiality of information relating to care; and hamper the teaching of resident staff.<sup>(2,4)</sup>

Other factors that negatively influence this practice include: lack of policies and specific guidelines to support the health professionals; and lack of infrastructure and support staff that welcome family members in the emergency room (ER).<sup>(3)</sup> Thus, in several units, the presence of the family is informal, unsystematic and inconsistent, depending mainly on the professional's self-confidence.<sup>(1)</sup> This triggers unfavorable outcomes in supporting family members, and causes negative perceptions on those involved with the family presence.<sup>(2)</sup>

In this sense, studies demonstrate potential disadvantages of this practice from the professionals' perspectives<sup>(7,8)</sup> or, at the most, dichotomize the understanding of the phenomenon into benefits versus limitations/losses.<sup>(9)</sup> The multifaceted perceptions and experiences of professionals who experienced emergency care, witnessed by the relative of an adult patient, are minimally explored<sup>(1,10)</sup> This limits the understanding of the reasons why physicians and nurses invite/allow families to accompany the patient during the care provided.

As nurses and physicians work collaboratively in emergency care, both can benefit from a better understanding of this phenomenon.<sup>(1,10)</sup> Based on the evidence presented, the objective of the study was to understand how physicians and nurses ex-

perience and perceive family presence in the emergency care service.

## Methods

This was qualitative research with symbolic interactionism as a theoretical reference, and grounded theory (GT) as a methodological reference. It was conducted in the ER of two public institutions that did not have institutional policies or systematic routines involving the presence of family in the service, with the decision left to the professionals. The two units allow the entrance of two people during the visiting period, which occurs twice a day, for 30 minutes.

These units were chosen due the differences in their physical structure, professional profile, and type of clinical patients, which provided greater data variability. For example, one of them is linked to a university hospital that is a high complexity reference for the 30 municipalities of the 15<sup>th</sup> Regional Health District of Paraná, attending to more serious, complex cases, and victims of trauma and violence; the other is part of the Municipal Emergency Care Unit, which mainly attends patients with clinical conditions and acute chronic diseases.

The data were collected between October of 2016 and February of 2017, with interviews that lasted 20 to 45 minutes, performed by the first author, who had no relationship with the interviewees, although he had worked in emergency services, as had the other authors. The interviews were guided by the following guiding question: *What is your experience/perception of the presence of family during the provision of emergency care?*

The only inclusion criterion adopted was to be a physician or nurse working in one of the ERs. Those who worked in the sector for less than three months were excluded, because it was believed that their contributions would be greater only after this period. As recommended by authors of GT,<sup>(11)</sup> theoretical sampling guided the data collection, and theoretical saturation determined the number of participants in each group. Twenty professionals were interviewed. The sample groups are shown in chart 1.

**Chart 1.** Presentation of the sample groups participating in the study

Sample group	Participating professionals
G1	Three nurses and two physicians working at ER1, located in a Emergency Care Unit (ECU), who pointed out the precarious infrastructure and management conditions as interfering with the invitation of the families. Analyzing the information of these participants showed that it was necessary to seek professionals who experienced different infrastructure conditions, with a better technological contribution and greater number of beds and professionals in the service.
G2	Three nurses and six physicians working at ER2, at a university hospital. Although to a lesser extent, for these professionals the aspects related to the management of the service also acted as intervariant variable in the presence of families. Thus, when identifying the saturation of the initial categories of this group, expanding the understanding of the phenomenon by including the managers of each of the participating units was attempted.
G3	Two nurses, each of whom was a manager of the unit, who were approached to expand knowledge regarding the management of the service in relation to the potentialities and fragilities for the realization of the family presence in the ER.
G4	Two nurses and two physicians, a physician and a nurse from each unit, acted as validators of the theoretical construct. Validation occurred after the completion of data analysis, and identification of the central category.

In agreement with the constant comparative method, the interviews were performed concomitantly with data analysis and the development of the sample groups.<sup>(11)</sup> All statements were audio-recorded. As the interview was transcribed, and the lines were edited, floating readings were performed, in order to understand the content of the text; an open codification began thereafter, using QDA Miner® software and the development of memos and diagrams.

The axial codification allowed a grouping of codes by conceptual similarities and differences, beginning with the identification of the categories’ properties, with the establishment of provisional concepts. Finally, the integration process allowed the densification of the categories and the aggregation of the concepts (Chart 2).

**Chart 2.** Representation of the data analytical process

Part of the analysis corpus	Sub-category	Category
<i>The climate of the emergency room is complicated; it is a busy environment, with aggressive procedures, where everything happens very fast. Maybe, the scenario may seem very unusual for the family, which distances the family from the emergency service (G4, Health Professional 20 - Nurse).</i>	Climate in the emergency space	Analysis of aspects concerning the environment and context
<i>[...] Sometimes, you do not even see the family around you, just because your focus is the patient (G2, Health Professional 7 - Physician).</i>	Philosophy of care	
<i>We need a structure that enables greater privacy, because I believe that if the person is there, he/she is there to accompany her loved one and not the patient next door. So, this privacy is needed. If the structure does not provide this, the family will experience the care and suffering of the other one, as well (G1, Health Professional 1 - Nurse).</i>	Physical structure	
<i>Today, we had a patient in the emergency room and no monitor was working! The nurses tried to change it, they messed around, but nothing worked. Will the patient die for lack of a monitor? Of course not! But, if the family witnesses this, not having materials, will they understand that? Without materials there is no way to put the family in the room (G1, Health Professional 5 - Physician).</i>	Medical and hospital supplies	
<i>A little is related to the protagonist of the subject. He, as a professional, chooses whether he will maintain a posture for bringing the family closer or if will further alienate the family [...]. So, it depends on the professional's attitude (G3, Health Professional 16 - Nurse manager).</i>	Human resources	
<i>[...] But you also have to remember the issue of contamination. Placing everyone inside the emergency room is critical, everything can be found there, for example, every now and then a patient suspected of having meningitis or tuberculosis (G1, Health Professional 3 - Physician).</i>	Infection related to health care	
<i>The critical patient, terminally ill, you have to argue, "Am I going to invest? Will I do cardiac compression on this patient who had a cardiac arrest?" "The family member may say, "My father always said that he did not want to be intubated, that he did not want to go to an ICU." The physician says, "Look, I need to do this" and the family says, "No, but he didn't want to." So we stopped here! It would be the family itself helping in clinical decisions (G2, Health Professional 14 - Physician).</i>	Level of complexity of the clinical condition	Analysis of aspects concerning patients and procedures
<i>Sometimes the family does not disturb. The fact that they are present, does not disturb a simple procedure. As long as we evaluate and see that the parents will not be a problem. But in extreme procedures I believe that they should not be around, because it would disturb us. Here, three times I had to perform an open thoracotomy. I have the impression that no family member would want to be in an environment where this is likely to happen (G2, Health Professional 11 - Physician).</i>	Level of complexity of the invasive procedures	
<i>[...] The family must be with a child patient. The mother or father should be present, and this is quite common. When attending a child is with the family on the side, it is all in front of the family (G2, Professional 07 - Physician). [...] For elderly patients, there are cases that we cannot restrain. In many cases we let them stay, so we can get information, and the elderly become less restless (G1, Health Professional 2 - Nurse).</i>	Patient age	
<i>There are cases in which I am no longer very strict in order to force the patient to be alone. Because, I know this is going to cause very great stress, and possibly it will have a worsening effect on the general health. So I leave it for a moment, but if I see that the family is not collaborating, I ask them to leave (G1, Health Professional 4 - Nurse).</i>	Possibilities of benefit for the patient	Analysis of aspects concerning health professionals
<i>I think the emotion stands out. We have to be more technical and do the medicine; we cannot involve emotion and medicine. The family presence, in a sense, puts pressure on the health professionals, the family ends up getting very emotional, very upset, and this sensitizes everybody (G2, Health Professional 10 - Physician).</i>	Psycho-emotional impact for the team	
<i>[...] My clinical attitudes do not change at all, whether it is the mother, the father, or whoever. I always make the same decision. We have to be professionals prepared to act in situations of stress (G1, Health Professional 5 - Physician).</i>	Education and preparation of professionals	
<i>The presence of the family gives more confidence, even for the physician, about some procedures, for example, he can ask the family member to explain to the patient what is going to happen, in an easier language (G3, Health Professional 15 - Nurse manager).</i>	Possibility of helping professionals	
<i>[...] It is fundamental [the family's presence] for them to also see that we do everything we can, everything that was to be done for the patient, we did (G2, Health Professional 8 - Nurse).</i>	Meeting the family needs	Analysis of aspects concerning the family
<i>Many times, it's a very aggressive relative. In this case it may be more disruptive than helpful, because we never know the reaction of a relative in a moment of stress. He/she may become violent, wanting to assault a staff person (G1, Health Professional 4 - Nurse).</i>	Family profile	
<i>Usually the companions are lay people, then, when you perform a more invasive procedure, for example, intubation, I think it's something that affects the person watching, to see it all, I think it's a bit traumatizing (G1, Health Professional 2 - Nurse).</i>	Family preparation	

The study was approved by the Ethics Committee of the State University of Maringá, opinion number 1,888,327 (Certificate of Presentation for Ethical Assessment - CAAE: 62787916.4.0000.0104).

## Results

Twenty professionals (ten physicians and ten nurses) participated, of which 12 were female. The age ranged from 24 to 60 years, time after graduation ranged from six months to 37 years, and time working in the ER ranged from six months to 32 years.

### Deciding “case by case”: searching for support to deliberate family presence/absence in the emergency service

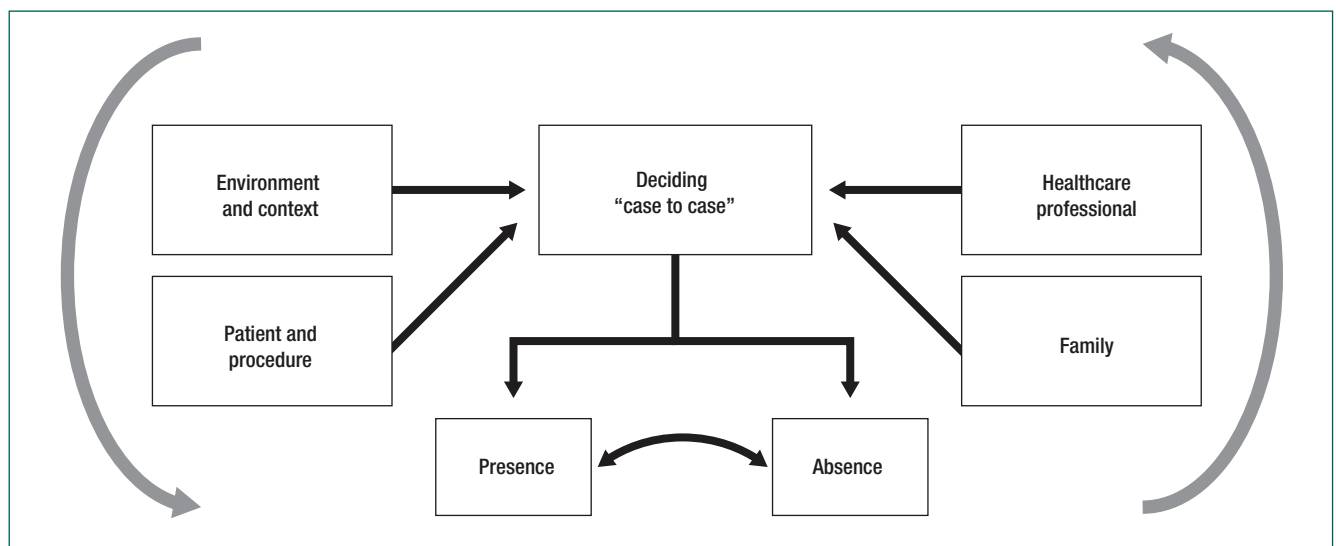
Professionals usually do not allow families to accompany patients during emergency care. In addition, there is a social culture of family exclusion, which, even if not formalized in institutional protocols/policies, is symbolic and widely accepted and shared by the staff. However, considering different aspects, families can stay with their loved ones. Thus, the expression “case by case” is recurrent in the professionals’ statements.

The phenomenon “deciding case by case” leads to the *presence* or *absence* of the family. The causal,

intervenient and contextual conditions are related to four major aspects: environment/context; relatives; patients/procedures; and, health professionals. The situation of allowing or refusing family presence is not crystallized, because during the care process, professionals tend to act, interact and evaluate constantly, leading them to review the decision to allow the presence of the family or not. Therefore, relatives who are present, sometimes depending on the clinical evolution of the patient and the activities/procedures to be performed, are asked to wait outside, while others, depending on how the patient evolves, are invited to be close to him (Figure 1).

Six aspects related to the environment and the context of the ER to allow or refuse family presence were noted. The climate in the emergency space, in general, is configured as highly stressful, agitated and troubled, making the place uninviting/nonreceptive to families. The frenetic sector routine also does not provide time to establish prior and welcoming contact with families - important for development of a family-professional bond, and to allow for the follow-up of care.

Family exclusion is also a reflection of the *philosophy of care* practiced in the emergency units. The care is exclusively focused on the patient needs, although it focuses mainly on those of physiopatho-



**Figure 1.** Relationship between the central category “Deciding case by case”: searching for support to deliberate family presence/absence in the emergency service” and its categories

logical order; the family, when present, is often not even perceived by the professionals.

According to the professionals, the physical structure also does not allow the staff to perform its functions with the presence of the family, nor does it provide privacy for patients and their families, preventing them from experiencing the suffering from the disease and its care. There is also professional discomfort with the fact that, sometimes, the family members observe the care of other patients.

It was stated that, sometimes, due to the lack of medical and hospital supplies, it is necessary to adapt the care and rescue protocols and, consequently, there is a fear of the families understanding the situation as a neglect of service. The lack of materials was cited as limiting only in ER1. However, the practice is not more common in ER2, showing that a sufficient amount of materials, per se, does not boost family presence.

The professionals stated a need for *human resources* prepared for work focusing on families, who are available full time and who are responsible for them, providing the emotional and informational support they need. However, managers believe that, in addition to the number of professionals, the welcoming and receptive attitude of staff are relevant so that the families can be invited/allowed to remain in the ER.

Physicians are concerned about the possibility of raising infection rates in health care, due to the unrestricted presence of the family in the ER, which is a “contaminated environment” because it treats patients with communicable diseases that may or may not be diagnosed.

Permission for family presence is also related to aspects concerning patients. For example, in relation to the clinical condition, the professionals better accept the family presence in cases of minor *clinical complexity*, because control of the situation is greater, the outcome is more predictable, and there is little possibility of death. For critical patients there are divergent understandings about the presence of the family. Some professionals identify it as unnecessary for unconscious patients - as they do not realize the closeness of these families. Others, in turn, understand that terminally ill pa-

tients should have the opportunity to die close to their families, including allowing family members to participate in end-of-life therapeutic decisions, and to say goodbye to loved ones.

As for the *complexity of invasive procedures*, professionals tend to allow the presence of families during those which are minimally invasive and/or that do not violate the patient’s modesty and intimacy. On the other hand, it is not well accepted/practiced when greater psychomotor skill and attention of the professionals is necessary, because stress hinders manual dexterity.

Regarding the *age of the patients*, in the case of children and the elderly, the family presence is understood as necessary, well accepted, and even usual in the emergency sector, because they are perceived as more fragile physically and emotionally. In addition, professionals often need family information to better provide care.

Finally, they consider the *possibilities of benefit for the patient* with more comfort; calmness, security, and receipt of individualized care. At times, family absence triggers stress and anxiety in the patient, worsening his/her clinical condition. Thus, professionals allow the family to be present, even for a short period of time, but enough for the patient feel more familiar in the environment and, consequently, calmer.

To allow or refuse the presence of families, **aspects concerning to health professionals** were analyzed. One of the barriers was related to the fact that professionals may be touched by family suffering, or feel pressured by the requirement of immediately decisive behavior. This psycho-emotional impact cooperates to emotionally stress the professional.

There were also aspects related to the *education and preparation of professionals*. Many of them do not feel empowered to act with families during emergency situations. Those who call themselves self-trained, realize that their clinical behaviors and psychomotor skills are not influenced by the presence of the family, and in these cases, they decide in favor of family presence.

Finally, the presence of the family is also conditioned by the *possibility of helping the professionals*,

as they can be seen as a potential collaborator in the communication process between the patient-team, offering useful information to establish the diagnosis, and transmitting the professional message in accessible language to the patient.

With regard to the **aspects concerning the family**, to allow the family presence, the professionals stated that they wish to meet family needs. These needs include: obtaining information about the patient's clinical condition/prognosis; feeling they are part of the care; transmitting strengths to the patient; understanding the critical health situation; identifying that everything possible was done; and accompanying the patient's last moments of life, enabling the farewell, which facilitates the beginning of the mourning process.

But to allow their presence, it is necessary that the family member have an adequate profile and prior preparation. In relation to the family member profile, the level of relationship with the patient, the fact of not being elderly, having good physical and mental health, and emotional self-control was analyzed. The need for *family preparation* is due to the fact that care is too technical and procedural. Without preparation, the family members may become traumatized by the scenes, which occur, get sick, become aggressive, or even blame the professionals for death, possibly triggering lawsuits.

## Discussion

The data presented enable us to understand the experiences and perceptions of professionals on family presence in the emergency service. Usually, families are barred from being with their family in the ER. However, in daily practice, a conditioned permission occurs, because of "case by case" analysis. This has already been identified in relation to cardiopulmonary resuscitation.<sup>(3)</sup> However, the present study advances this understanding, because it reveals that this conditional permission extends to different types of emergency care, and also because it indicates that the final decision is influenced by aspects related to the context, family members, patients, and professionals.

Physical space, for example, was considered inappropriate for receiving/welcoming the family. Similarly, an Australian study of emergency physicians showed that organizational factors, such as lack of space and support for families, as well as excessive workload, were the main reasons for not allowing family members to witness care.<sup>(1)</sup>

The environment of the ER, as a result of the type of care provided, is considered violent and aggressive for the family.<sup>(4,12)</sup> Therefore, people who work in that scenario, feel themselves to be clothed with authority and even legitimate power, in the name of protecting the families, excluded them from the space of care.<sup>(3)</sup> In addition, professionals refer to focusing their attention on the critical ill patient, in an attempt to save their life.<sup>(5)</sup> The patient is therefore, the center of care.

It is believed to be opportune and urgent to discuss and encourage the possibility of adopting the philosophy of Family-Centered Care (FCC) in emergency units. Professionals from different countries recognize the innumerable challenges to implementing this idea in these sectors, but they perceive it as the driving force for qualification of care for critical patients and their families, by humanizing care.<sup>(7,13,14)</sup> In the Brazilian context, FCC is still very incipient, not implemented in health services, or discussed in vocational education.<sup>(15,16)</sup>

In this investigation, the professionals emphasized that the complexity of the invasive procedures, the severity of the clinical condition, and the possibility of death were determinants for the family's withdrawal from the ER, which is in line with the results of studies conducted in Brazil<sup>(17)</sup> and Australia.<sup>(5)</sup> However, it is also understood that the family presence should be promoted when the patient has little chance of survival, so that they can say goodbye.<sup>(2,3)</sup>

The results also showed that professionals are more likely to accept the family presence when the patients are children or elderly, as demonstrated in other investigations.<sup>(1,3)</sup> In the case of children, the support for the presence of parents can be explained by nutritional dependence and by the close relationship between parents and young children,<sup>(3)</sup> in addition to the perception that ex-

cluding parents during hospitalization of a child is detrimental to their well-being.<sup>(18)</sup> However, if professionals are willing and able to overcome the personal and organizational barriers to facilitate the presence of parents during pediatric emergency care, the reluctance to adopting the same attitude for the adult patient must be analyzed.

The answer to the explicit question is not ready and it does not seem easy to construct/reach it. However, one clue may be in the identification of the existence of a culture of exclusion of the adult patient’s family, which is widely accepted and shared by the professionals of this investigation. Similarly, another GT study identified that practitioners in emergency services claimed ownership of the patient and, even without institutional policies prohibiting the family presence, they felt they held the position of authority to allow or deny it, which was widespread among colleagues, relatives and patients, as the families showed little resistance to exclusion.<sup>(3)</sup>

This professional understanding may be related to a lack of awareness of the family presence. In fact, in this study, professionals perceived the absence of education focused at the adequate welcoming of families. It is believed that changes in the process of initial education and continuing education of professionals may enhance the sense of self-confidence during the care provided under the eyes of family members, while at the same time they seem to be feasible strategies to be engendered.

Not including families during education is not an exclusively Brazilian problem. A study with Australian critical care nurses, for example, showed that education was considered to be inadequate to meet the needs of families in the moments preceding and following the death of patients.<sup>(19)</sup> On the other hand, there are encouraging examples of Denmark,<sup>(20)</sup> the United States<sup>(21)</sup> and Canada,<sup>(22)</sup> which recognize the importance of training generalist nurses with competencies, mainly attitudinal, that favor the welcoming and care of patients and their families.

Also, a study conducted in the United States showed an increase in permission for the presence of families after educational interventions with the professionals of an emergency unit.<sup>(23)</sup>

However, in South Korea, researchers have suggested developing and implementing an educational program to modify the negative perception of professionals about the presence of families in ER.<sup>(24)</sup> These studies, therefore, show that changes in the formative process collaborate to diminish the symbolic culture of professional exclusion.

Another relevant aspect is the possibility of developing strategies to raise awareness so that the professionals in the exercise of otherness can be strengthened. Sometimes, in this research, professionals assume the role of the other in the interactional process, facilitating the understanding of the desire to be with the loved one. The nursing team, for example, when witnessing the family’s experience of death, can demonstrate feelings of compassion and solidarity and, in putting itself in the place of the family that suffers, can better understand their needs.<sup>(25)</sup> This has the potential to reduce the rigor used by professionals to select the ideal family profile that can accompany the patient during care.

Finally, it is highlighted that in the absence of structured protocols, decision-making and clinical practice is guided by the professional self-confidence, as well as individual perception, experiences, and beliefs about family presence in care. This explains the wide variations identified in this study and in the literature, culminating in an inconsistent and sporadic family presence.

The interviews were conducted during the participants’ workday, which may have contributed to more superficial responses, as some participants were concerned about returning to their activities.

## Conclusion

For physicians and nurses, the presence of the family in the ER is configured as a complex and multiterminated process. Aspects related to: environment/context; families; patients/procedures; and, themselves were considered in the decision. However, because the phenomenon is heterogeneous and has multiple facets, this decision is not crystallized, as it is constantly considered throughout the care, and performed in a different manner for each case.

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## Collaborations

Barreto MS, Marcon SS, Garcia-Vivar C, Furlan MC, Rissardo LK, Haddad MCL, Dupas G and Matsuda LM declare that they contributed to the study design, analysis and data interpretation, relevant critical review of the intellectual content, and final approval of the version to be published.

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