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EMPIRICAL STUDY

The bodily presence of significant others: Intensive care patients' experiences in a situation of critical illness

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Abstract
This study is about intensive care patients and the bodily presence of significant others. The aim of the study is to inquire and understand the patients experience of the body in relation to their significant others during critical illness. Open, unstructured, in-depth interviews with six former intensive care patients provide the data for the study. The phenomenological–hermeneutical analysis points to a theme among ICU patients' experience of conflict between proximity and distance during the bodily presence of their relations. Patients experience different and conflicting forms of responses to the presence of their significant others. Patients experience significant positive confirmation but also negation through this presence. In the ICU situation, the reactions of significant others appear difficult to deal with, yet the physical presence is significant for establishing a sense of affinity. Patients seek to take some responsibility for themselves as well as for their relatives, and are met with a whole spectrum of reactions. Intensive care patients experience the need to be actively, physically present, which often creates sharp opposition between their personal needs and the needs of their significant others for active participation.

Key words: *Phenomenology, hermeneutics, intensive care patients, critical illness, significant others*

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Background

Critical illness affects patient ability to relate to and share with their significant others (Fredriksen & Ringsberg, 2007). The patient already faces critical illness; the situation is unfamiliar, stressful, and caused by sudden upheavals in the person's life. Suddenly the patient is experiencing an abrupt transition from independence and freedom to the rigorous structures of an intensive care unit (ICU). The patient's life is at risk from (imminent) loss of vital functions. This change of conditions in life creates dependency, personal expectations, and role changes in the presence of significant others. Affiliation and the experience of having significant others present, can be observed in the patient's sense of coherence in a situation (Benner & Wrubel, 2001). The patient's opportunity to be an active participant in the situation depends on his/her coping strategies.

The focus in existing research into the relationship between adult patients and their significant others has until now been random. One focus has been on significant others and their requirements and experiences from intensive care situations (Alvarez & Kirby, 2006; Hardicre, 2003; Verhaeghe, Defloor, Van Zuuren, Duijnstee, & Grypdonck, 2005). Another focus has been on the ICU unit and the nursing services provided to patients and their significant others after discharge (Chaboyer, 2006). A third focus has been on communication with intensive care patients and their significant others regarding terminal care (Curtis, 2000). One survey also illustrates nurses' experiences with families who have lost relatives during intensive care (Andrew, 1998). A fourth and final focus looks at physicians' visitations to patients in intensive care, discussing flexible solutions, and how visits from significant others can benefit patients (Farell, Joseph, &

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Schwartz-Barcott, 2005; Kelleher, 2006; Sims & Miracle, 2006).

A separate research field in which the relational dimension between the patient and significant others is a key component is within phenomenological–hermeneutic analysis. This tradition looks at the body as a subjective reflected body as opposed to traditions in which the body is considered physiological and cognitive (Thøgersen, 2004). This ontological understanding of the body is characterised by what we see of individual persons' lived lives, coupled with awareness and recognition of one's own being in the world (Nortvedt & Grimen, 2004). This consciousness and recognition is based on the acknowledgement that man does not exist alone and isolated, but lives and acts in the situation(s) (Heidegger, 1962; Martinsen, 1993). The being present in (and with) body in a situation, offers certain experiences. Our involvement in the situation challenges the way we deal with the world around us (Benner & Wrubel, 2001). This sensuous community also leaves the critically ill patient with impressions from his/her significant others when they are present in the form of tuned sensing (Løgstrup, 1995). Tuning makes mankind aware of reverence and shame. These are ontological life necessities (Martinsen, 1996). The span between reverence and shame creates tension and opposition in the situation, which leads to a revelation of the critically ill person's relational life in a context where he cannot exclude relationships, because he is in the world with his being (Løgstrup, 1982). What it is like to be in physical proximity to one's significant others during critical illness, can only be revealed by those who have experience. Critically ill persons' experiences in relation to their significant others have hardly been scientifically investigated (Fredriksen & Ringsberg, 2007; Storli, Lindseth, & Aspelund, 2008; Tracy & Ceronsky, 2001). The purpose of this study is to bring to light experiences from intensive care patients about their relationship to their significant others, and the importance of these relationships in a situation of critical illness.

Method

This study applies Kvale's (1997) phenomenological–hermeneutic methodology; by using interviews to gather data from intensive care patients, and a three-step analysis. The method is characterised by an open, communicative, and pragmatic dynamic, inspired by hermeneutic theory. According to Kvale (1997), it targets continuity between descriptions and interpretations during all the phases of the research process in order to reveal the informer's experienced lifeworld.

Access to the field of investigation and selection of respondents

Written permits were collected from three hospitals in Northern Norway, to contact former intensive care patients. Staff nurses distributed the questionnaire to potential respondents selected on the following inclusion criteria:

1. 18 years +
2. Five days or longer in intensive care

Data collection and analysis

Data was collected through in-depth interviews with six former intensive care patients between the ages of 20 and 75 years of age (one male and five females) within 6 months after discharge from hospital. The informants were chosen by convenient sampling. The male patient suffered from an acute infection. Two of the female patients were treated for pulmonary disease, one treated for an infectious disease, one had received surgery for cancer, and one suffered from intoxication due to substance abuse. All patients were on life support (most of the time) in the ICU and could not communicate verbally. The interviews were conducted in the form of a dialogue between the respondent and the researcher and carried out by way of narratives where the information rendered became the premise for the interview's content. The respondents commented that they appreciated communicating their experiences to someone who understood what they were referring to. Interviews were taped and transcribed word by word. The patients' significant others were close friends, wife, husbands, daughters, and mothers.

The three-step analysis of the interviews involves: (1) self-understanding, (2) common sense, and (3) theoretical interpretation. The first phase sums up the respondents' personal conceptions of the interviews from the perspective of the authors. This understanding develops from reading the interviews thoroughly, and extracting essential knowledge from the material according to the intensive care patients personal experiences of significant others.

The second phase goes beyond the personal conceptions of the respondents, and integrates relevant data from the authors' knowledge base, while the researchers maintain a general level of understanding. The subthemes, which form the structure of common sense, were analysed through dividing the interviews into narratives. Each narrative (consisting of an introduction, a midsection with at least two units of meaning and a conclusion) was then compressed and interpreted according to totality and context in a hermeneutical process.

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During the third and final phase, the researcher applies theoretical knowledge in order to interpret the meanings of statements. In this case the knowledge base is within phenomenology and hermeneutics that provides the in-depth understanding. The presentation of the findings includes phases I and II of analysis, while phase III is covered in the discussion in this article.

The first author has conducted the collection of data and has had the chief responsibility for interpretation. The interpretation process should be viewed in light of the first author's competence, understanding, and experience as teacher in intensive care nursing. The second author has followed the process and supplied critical comments and suggestions.

Research ethics

The study was approved by The National Committee for Medical Research Ethics Region 5 and by the Norwegian Social Science Data Service. The respondents' consent to take part in the study was submitted directly to the first author.

Findings and interpretation

The analysis reveals a superordinate theme relating to the phenomenon of significant others' bodily presence and the conflict between proximity and distance. The superordinate theme is derived from analysis and interpretation of six subthemes of physical proximity of significant others. Findings are presented, interpreted, and organised according to Table I.

Table I. Overview of subthemes and themes related to intensive care patients' experience of physical proximity of significant others.

Sub-theme	Theme
Opposite bodily reactions to the presence of significant others	The conflict between proximity and distance to significant others
The conflicting character of reinforcing actions	
Ambivalent reactions to experiential expressions of significant others	
Shared experiences may both reinforce and weaken a sense of community	
The challenge of drawing the line between personal and collective responsibility	
How bodily proximity to significant others and inability to communicate may cause difficulty and conflict	

Opposite bodily reactions to the presence of significant others

Patients talk about their sensuous bodily reactions in a subconscious state, for example to recognise their significant others when they spoke or touched the patient's body. Some patients talk about the empowerment the prayers of their loved ones create. Some have experienced strong bodily responses to Reiki (a technique for stress reduction and relaxation). "They applied reiki ... gave me strength ... it was quite indescribable" (Female 75 years).

These positive experiences create moments of bliss for the patients, but can also have the opposite effect on their health condition. Some patients describe how the presence of significant others drained their resources and energy.

> ... I felt crammed ... my body stiffened ... my shoulders became rigid and my chest constrained ... I felt pushed into a corner. (Female 54 years)

Such reactions to significant others' bodily presence may be seen as restricting the patient's body. It is a conflict between capacity and expectations in themselves or in their significant others created by the presence and the situation.

Some patients describe an increased sensitivity to temperature and an exhausted body that didn't function caused by the presence of significant others.

> ... I couldn't have you there ... I am so tired ... sending them away broke my heart, but I just couldn't have them there. (Female 34 years)

The presence of significant others at an ICU is in principle positive. But the fact that the patient is critically ill seems to create a dilemma and sometimes a choice of admitting visitors or creating an environment in which the patient can rest and focus on basic life support.

The conflicting character of reinforcing actions

Reinforcing actions are very significant to the patients but may also cause conflicts. The significance of holding the patient's hand as an expression of love and care may also create a sense of loss and solitude. Gifts, letters, and notes from significant others remind them they're not forgotten, yet the significance of significant others can also be registered in their comments to vital aspects of the situation.

> ... get well soon, please remember to eat, you need to exercise, you need to ... I didn't mind

> hearing this from my parents . . . but when friends did it, I felt they were nagging. (Female 34 years)

The significance of parental presence was high among those who experienced it, but also riddled with conflicts. Their presence was felt as "something bound to the body—a blood relation," which they needed and feared losing if the parents left. The patients also experienced that assertive situations had a reinforcing effect. When the situation is assertive and difficult, the response from those who are familiar with the patient's life and history may be the factor that confirms or refutes whether the patient's experience is based on facts or fiction.

> . . . I told my daughter we were on holidays and that I was ill. And she could tell me no, you haven't been there . . . and I learnt more . . . and suddenly everything seemed to fall into place. (Male 64 years)

This situation can be seen as moving between different dimensions where the conflict between proximity and distance to significant others can be observed in the patient's reactions to the worldly dimension that is most pressing at the moment, and which position the significant other has in this dimension.

Ambivalent reactions to experiential expressions of significant others

The ICU patients describe how they are affected by the bodily expressions of their significant others. They reveal how significant others compare reactions and draw parallels to their own situation; by explaining that their own situation had been worse or that their own coping strategies were better. Patients with small children found it particularly difficult to sense what their children understood and worried when children reacted strongly to their parent's lack of coping the way they expected the child to.

> . . . hard to know how much they understood of it all . . . I've spoken to the eldest quite a lot, the two others have reacted like mommy you are stupid, mommy you are ill and you are silly not to be out of bed. (Female 34 years)

This is typical for the ambivalence in children, the expectations of parental involvement and the distant incapacity and inability of the ICU patient. Children's expressions may provoke emotional conflicts since critical illness prevents their parents from natural intervention. Patients are also often directly affected by the reactions their significant others display. The presence of their most important significant others allow patients to live in a dichotomy between sharing and distance. "... he (husband) is the one I have shared most of my life with . . . but not everything in it" (Female 54 years).

This is the loneliness of sharing with someone, sharing some things in life and keeping other things private. In this context the ICU patient's body exists in existential movement between seclusion and distance and being near to the other (Fredriksen, Talseth, & Svensson, 2008). Some ICU patients see their significant others expressing their suffering as anger, fear, and despair while others hide their fear and vulnerability. Some responses from close relatives were particularly strong.

> . . . she (mother) had me as her favourite, but this was beyond anything I had experienced . . . and . . . I never noticed until I saw it (in the ICU). (Female 20 years)

Patient experiences reflect a sense of vulnerability derived from their significant others' appreciation and sacrifices, but patients also feel a sense of shame and guilt from being unable to reciprocate. When their significant others were encouraging and hopeful this benefited the patient's situation. This positive attitude appears in small remarks like:

> . . . almost a month in coma . . . / / . . . I was in (coma) . . . then my little girl said that the last thing you lose is the ability to hear. (Female 70 years)

This is power significant others can provide, which creates hope, but also hopelessness in which the patient's will to struggle may be lost.

Shared experiences may both reinforce and weaken a sense of community

It is a strong desire among ICU patients to have their significant others bodily present, and particularly parents, spouse, or partner. "... mommy was here . . . she was mine . . . you know mommy is mommy . . . you see" (Female 20 years).

Experiences like these indicate the existence of a close bodily relationship, but these assertive phrases may also contain a fear that this relationship may be threatened. Confidence and trust are important to patients in the ICU unit, but some significant others seem to provide trust better than others. Trust is described in the following statement. "... what I told her stayed a secret with her, and what she told me stayed with me (Female 53 years)."

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Trust is a shared community between individuals who create trust, but can also become the opposite when trust is not an obvious element in the situation. Some patients said it is alright for their significant others to come for short visits, as long as they knew they were coming. Others didn't even need them present in the room as long as they knew they were nearby. To others the complete opposite was the case.

> . . . it felt safe having her there . . . and knowing she was there . . . then she had to leave the room for a moment, I must have slept . . . and I called her . . . she didn't answer . . . several times . . . finally I panicked. She was gone. (Male 64 years)

To these patients the presence created safety on a significantly more existential level. Patients also describe what it's like to be at the centre of their community. They reveal how significant others have wanted to come because they felt obliged, but have ended up being there for the patient. Patients often feel they take priority over other family members and that some of their loved ones take time off from their work to visit.

> . . . when I opened my eyes my kids were there and said mommy we're here . . . then I relaxed and . . . I guess it gave me the strength to fight. (Female 70 years).

Sharing community and the confirmation significant others provide by focusing on the ICU patient is significant to the sense of belonging. This form of affirmative inclusion patients experience is significant for their life courage and seems to positively affect the healing of the body. Sharing community with significant others may be difficult for some patients because of a lack of capacity and a need to protect themselves in the situation. Leaving the responsibility in the hands of their significant others is also seen as a positive characteristic of the community. The ICU patient feels stuck in the middle between their personal sense of incapacity and the demands they experience in the situation.

> . . . consciously or unconsciously I have pushed them to their limits . . . I wanted them to take control over my life and make decisions again. (Female 34 years)

This can be understood as a strong desire to be liberated from the strain they are under as patients, and to limit the focus on self—giving them the opportunity to rest.

The challenge of drawing the line between personal and collective responsibility

Patients feel responsible for explaining to their spouses or calming their parents and being in charge of organising the agenda of significant others, deciding who should come, and at what times. This role also applies to the limits they set for their spouses.

> . . . not allowed to visit three times a day . . . he was pallid and tired . . . I had to take charge so he wouldn't collapse, I had to look after my family. (Female 34 years)

Patients understand their own position, but also the position of their significant others. They respond to significant others' situation and act to prevent further development in and adding strain to themselves as well as their loved ones. By being in charge they also consider what would be best for their close relatives and what they need to be shielded from. Patients hid their personal pain in situations where particular medical instruments were used, so that it wouldn't mark the memory of their significant others, especially the children. They also hid the truth by distorting or altering facts to shield their significant others.

> . . . must not feel responsible . . . not to be so frightened . . . no I guess it is to protect them . . . I know how hard it was for them when I was in intensive care. (Female 60 years)

The ICU patients tried to reduce the strain on their significant others and to soften reality. From this it is possible to deduct that the patient makes a choice between taking charge or leave responsibility to their significant others. Patients often chose to carry this burden alone. ICU patients fear for their significant others and try to make sure their significant others are continually updated by staff or try to comfort their significant others themselves. They are concerned with how their loved ones cope at home, practically, but also emotionally during this difficult time.

> . . . I had so much on my mind . . . I thought of the children . . . the grandchildren, what would happen to them . . . and the man I had lived with for more than fifty years. (Female 75 years)

The fear and involvement patients demonstrate in the lives of their significant others is a testimony of love, care, and dependency between patients and their significant others, but it is also symbolic of a

fear of how their loved ones' lives would develop without them.

How bodily proximity to significant others and inability to communicate may cause difficulty and conflict

Two patients revealed that they were unable to communicate due to the fact that they were connected to life support. However, another patient who had sufficient strength could communicate via mobile phones to significant others who were there or physically somewhere else. This contact was important and created a sense of proximity. Those who were unable to directly take part in communication in spite of the fact that they had their significant others physically present express a sense of difficulty and of conflict. "... I could hear them talking among themselves ... and I didn't agree ... but I couldn't (talk) ... it was horribly upsetting" (Female 54 years).

In this dilemma one is physically close but distant, in the sense that the patient becomes an object by being unable to share and communicate. Patients feel excluded from planning or interacting with their significant others because of their illness and loss of communication. The sense of being excluded also involves being restricted from everyday verbal contact with their significant others and especially their children. "... it is obvious that when you have been denied access to your family ... you become so lost" (Female 34 years).

It may seem as if ICU patients' experiences not only refer to being excluded from individual situations, but reflect a complete existential problem. This is not only a question of lack of communicative capacity but also involves distance between two sets of situations with different preconditions and purposes. Patients say they feel distance through limitations as if they were infants, unable to walk or talk. Those patients who have children feel exposed to demands that they are bodily incapacitated to fulfil.

> ... he wanted to lie in my arms like he used to at home ... a small kid with diapers in the nook of my arm ... I wanted to but I was totally exhausted. (Female 34 years)

The communication limitations in the presence of significant others can be seen as a situation in which body and consciousness exist separately—there is a will, but not a way for the body to follow-up on the intent of the will. For patients; they not only lack the strength to comfort and cuddle their close ones, but also lack the opportunity to communicate due to the loss of speech. This split situation seems to create an existence that is characterised by two sets of attitudes towards significant others: one seeking proximity, the other causing distance.

Comprehensive understanding

The analysis shows that intensive care patients' experiences with bodily presence from their significant others is noticeable in bodily reactions. Patients compare their own responses to situations with those of their significant others and dealing with the situation in a similar way. These reactions often occur in situations when the significant other tries to encourage the patient to get well from a serious condition. Situations become unpleasant confirmations of the patient's situation as critically ill. When they are together with their significant others patients experience support. Such confirmations may be in the form of physical presence and verbal confirmation of family bonds, but these confirmations also significantly help the patient use the support from their significant others and understand conditions and contexts in the situation (s)he is in. Being with one's significant others affects the patients' physical response patterns. It is visible when patients are in a situation where they feel the need to be active participants, but often end up feeling lonely and excluded. Sharing community with significant others brings out the patient's fear that community, trust, and safety is at risk. In spite of the fear of separation, patients often feel that their significant others make an effort to prioritise them before other members of the family. Feeling personally responsible for their significant others is a strong characteristic among intensive care patients. They address their own situation by setting boundaries, but they also assume responsibility for their significant others, trying to protect them and by informing them of the situation. Sharing the bodily presence of significant others is important for the patient. The dichotomy of this position is a mental willingness to interact, limited by a situational and physical incapacity to respond.

Discussion

The dynamics between proximity and distance is a universal phenomenon and closely linked to human autonomy. This dynamic involves choices of a relational character (Retzinger, 1991). ICU patients face difficulties due to the limitation of choices they are subject to, since their situation contains elements that restrict their opportunity to chose their preferences among significant others (Fredriksen et al., 2008). This mindset changes the patients' experience from freedom to choose, to a situation of

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conflict between proximity and distance to their significant others.

Patients experience the conflict between proximity and distance with various bodily responses. The bodily presence of significant others is in principle a positive experience, however—in a situation with critical illness and the limitations it involves—patients experience the conflict between the presence of significant others and the exhausted body's need for rest and protection against all unnecessary impressions in order to survive. Significant others affect the situation and create a sense of constraint and disempowerment. Patients receive their significant others with sensuous openness, yet are unable to disconnect their sensing, since they are unable to control their own body, its place, and position in the world (Merleau-Ponty, 1994). Thus the patients open sensuous body is ruled by intentionality, their will to live, and independence on one hand, and the constraints of the demands of physical presence of significant others and its effects on the critically ill body on the other. The bodily presence of significant others also confirms patient experiences and are significant to the situation. Patients reveal how touch confirms the sense of belonging. Significant others also make demanding comments, comments the patients feel nagging, remarks that reinforce their sense of being nonproductive. This confirmation focuses on relative involvement in the situation and expectations linked to involvement—in other words how much the patient can contribute (Thøgersen, 2004). The demand for participation is a double-edged sword. On one hand it confirms a sense of community, on the other it confirms alienation because of the gap between expectations and patients' ability to perform. The only situation where this contradiction is nonexistent is in the bond among close blood relatives, where no demands are made for performance—an unconditional demand towards giving to and receiving from the other (Løgstrup, 1999).

Man always relates to a meaningful holism in his being in the world and this connects ICU patients' experiences and relationships to the responses they receive from their significant others (Nicolaisen, 2003). ICU patients see significant others suffer in silence when they enter into the relationship with closed emotions and with bodies devoid of spontaneous emotions. They reveal how some significant others try to seem tougher than they are, but since they know each other intimately they find it difficult to decide how to relate and how to deal with the situation. These and other statements indicate conflicting emotions that may result in bodily reactions, reactions in the form of life suffering. When more than one significant other is present at the same time, patients express how they must balance the difference in reactions among their visitors. The patient is forced to relate to other people's reactions and must cope with proximity and distance simultaneously. This involves how intensive care patients experience significant others' concern, as well as their desperate hope in the situation. The strength of hope opens up an existential dilemma—the contradiction between other people's hope and one's own experience of the situation. This position doesn't only create a dilemma of proximity and distance in itself, but also an openness to or reservation against life itself, caused by the strong sensibility of the situation. This sensibility may affect the life force through the patient's senses (Nortvedt & Grimen, 2004).

Community is sharing, bonding, lineage, family, faith, or attitude for shorter or extended periods of time in a life span. ICU patients reveal that the bodily presence of significant others during critical illness is important in terms of closeness, openness, confidence, and their need to be there. Being close to one's own, particularly one's children, is perceived as difficult since it touches on thoughts of dying and the fear of having to leave a shared community through death. ICU patients also reveal how they feel limited in the community, since they must leave tasks and responsibilities they otherwise would have handled on their own to their significant others. At other times they are forced to renounce significant others in order to cope with their own life and the situation. On the one hand we see a form of existential confidence that serves to confirm their position in a shared community (Nicolaisen, 2003). On the other hand there is a message beyond the (fundamental) experiences in the situations where spontaneous life utterances create meaning as well as provide meaning. It is characteristic for human nature to care for someone or something, and this makes the total experience a situation of division and conflict. Existential safety and the experience of fear, create an understanding of inadequacy (Benner & Wrubel, 2001).

Family relations and community involves personal and shared responsibilities (Alvarez & Kirby, 2006). By defining themselves as decision makers, ICU patients protect adults and children from additional stress by shielding them from facts about their situation. ICU patients make assessments and interventions and carry the consequences and responsibilities alone. They represent their own illness and the situation they are in, as well as in how the consequences of physical presence of significant others manifests itself in their separate bodies. ICU patients seem to support their loved ones and carry them "in their hands." This attitude among patients seems to create a situation that feels brighter and safer to those

who are closest to them (Løgstrup, 1999). Simultaneously patients experience personal, embodied life suffering by being forced to make decisions against a strong desire to be with those who are dear to them and who matter most to them. A situation, in which the patient places the needs of their loved ones before their own, may ultimately create an existential condition in which bodily presence—with all its contradictions—becomes the confirmation of being there for the other (Martinsen, 1993).

Interaction confirms relations, but interaction also confirms the impression of the self and/or supports life (Martinsen, 1996). ICU patients confirm the importance of communication and that talking to their loved ones on their cell phone was positively significant. Talking face to face, however, could have the opposite effect. When they were not asked for opinions or included in discussions, they felt rejected. Serious illness is in itself an exclusion from community according to some patients. Inclusion in a relational community is confirmed by an ethical presence as well as actions within the relational community (Løgstrup, 1999). When ICU patients experience closeness when the physical distance to their significant others is vast and vice versa, it becomes a dimension of relational ethics; since being seen, heard, and understood lies beyond the borders of physical presence. True reception embraces the other and includes the other in the relationship. The contradiction appears when significant others make plans without including the patient or making the patient's opinions, actions, or presence heard or seen in the relationship. Since the patient is critically ill and bound by limitations, the span between being present in the relationship or not becomes a conflict and existential pain instead. Additionally, when relational interaction is substituted by life suffering, the situation may become a threat to the ICU patient and to life itself.

Clinical implications

Relational proximity, in this case the ICU patient's experience of bodily presence of their significant others, can be registered in physical responses, affirmative responses, the perception of significant others' responses to the patient's illness, and the community patients/significant others share.

Knowledge based on the reflected body's expression provides intimate access to understanding the reality of patient experiences. This knowledge represents an unusual form of insight into life from the perspective of a challenging situation, in which the bodily presence of significant others is vitally important to the patient's life. This form of insight poses a different challenge to ICU staff by adding a different perspective, philosophy, and knowledge. It forces ICU staff to reconsider their own experiences and knowledge of the patient/significant others interaction and the phenomena they observe—in essence a physical meeting. Without information on how the patient experiences physical presence of their significant others, important elements of patient assessment may be lost and affect improvements towards ICU patients' relational needs.

The staff is usually responsible for facilitating meetings between patients and their significant others in the ICU unit. It is therefore essential that they apply their knowledge. This is not only significant when it comes to practical actions within the health professions in the ICU units, but also raises a question of what educational strategies need to be chosen, what knowledge is essential, and what themes should be included in national educational strategies.

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