What's new in ICU visiting policies:

Can we continue to keep the doors closed?

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Restricting visiting in ICUs is neither caring,

compassionate, nor necessary

Berwick DM, Kotagal M

(*JAMA* 2004)

Twelve years ago, Hilmar Burchardi wrote in an editorial in Intensive Care Medicine that 'it is time to acknowledge that the ICU must be a place where humanity has a high priority. It is time to open those ICUs which are still closed' [1]. The intervening period has undeniably brought about some changes in the direction indicated by Burchardi. However, the admission of patients to Intensive Care Units (ICUs) still follows a 'revolving door principle': when the patient comes in, the family is sent out.

In the past few years several authoritative recommendations in favor of the liberalization of visiting policies in ICU have been published [1-3; see also Table 1]. Nevertheless, in many countries these recommendations have not significantly influenced our clinical practice. The literature gives a patchy picture of visiting policies and the percentages of adult ICUs without restrictions on visiting hours currently range between 2% and 70% [4]. Despite the many objections considered valid in the past (mainly infection risks, interference with patient care, increased stress for patient and family members, violation of confidentiality), there is conclusively no scientific basis for limiting family presence in ICU [1, 2]. On the contrary, there are strong arguments for liberalizing access to ICU for patients' families. Current knowledge shows that separation from loved ones is a significant cause of suffering for the ICU patient [5], and that for the family, being allowed to visit at any time represents one of the most important needs.

There is now wide broad consensus that the liberalization of visiting in ICU is a useful and effective strategy to respond to the needs of both patients and families. In particular, an unrestricted

visiting policy causes no increase in septic complications [6, 7], while cardio-circulatory complications, anxiety scores and hormonal stress markers are significantly lower [6].

Alongside the patient's suffering there is also that of their family and loved ones, which is given scant consideration: relatives of ICU patients very often develop post-traumatic stress symptoms (PTSS) and high levels of anxiety and depression [8, 9], while an 'open' visiting policy contributes to an effective reduction of anxiety in patients' families [10].

Particularly in the area of health, the choices we make and the reasons behind them must be weighed up to assess their acceptability on an ethical level. The Italian National Committee for Bioethics (INCB) [see Table 1] recently highlighted the fact that liberalizing visiting policies is a concrete expression of the principle of respect for the person, and is consistent with the principles of autonomy, beneficence and non-maleficence. In the view of the INCB, based on current scientific knowledge, the presence of loved ones at the bedside does not in any way constitute a threat to the patient. On the contrary, it has a beneficial impact on both patient and family. In particular, the INCB states that 'from an ethical standpoint it is unjustifiable – unless in absolutely exceptional cases – to fail to perform a positive action which can provide benefit to the patient'. On both ethical and clinical grounds only serious health risks can exceptionally justify restricting visits.

The INCB echoes the point of view that 'opening' the ICU is not just a question of time: we also need to consider 'openness' in terms of physical and relational dimensions [11]. The *physical dimension* includes all the barriers recommended to or imposed upon the visitor, such as no physical contact with the patient or gowning procedures, which are of no value in infection control [1]. The *relationships dimension* involves the communication – often compressed or ineffective – among ICU staff, patient and family. If we also address these aspects, an 'open' ICU may be defined as a unit in which one of the caregivers' objectives is a carefully considered reduction or elimination of any limitations imposed on these three dimensions (temporal, physical and relational) for which there is no justification [11].

We have thus far discussed several well-grounded reasons to implement open visiting policy in the ICU [3]. However, two further arguments need to be addressed. Firstly, an ‘open’ policy not only helps to respect and preserve the patient’s ties with family and friends, but also allows family members to be involved in the treatment, by acknowledging and putting to good use the many tasks they may perform for their loved one [12]. In the critical care setting the family is actually a resource rather than a hindrance. For instance, a diary kept by family members and ICU staff can significantly reduce PTSS in surviving patients and relatives one year after discharge [13].
Secondly, ‘opening’ ICU is an achievable aim and is highly appreciated by doctors and nurses after implementation. Although in its initial phases the liberalization of visiting, like any major organizational change, may cause some psychological distress among ICU staff-members, nevertheless most of them view the ‘opening’ of the unit positively and maintain this opinion after implementation [4]. Moreover, they acknowledge that the policy change also brings about beneficial effects for ICU staff such as improved communication with families and increased trust from families. Similarly, a French study highlighted that most caregivers in ICUs with unrestricted policies perceived this favorably, as only 10% preferred reduced visiting times [14]. Moreover, 81% of these staff-members stated that an unrestricted policy contributed to improved relations with families. Another study reported that after implementation of a 24-hour visiting policy, neither doctors nor nurses perceived ‘open’ policy as disrupting patient care [10].

By welcoming families and visitors in ICU we, doctors and nurses, are not making any concession to the patient. Instead, through this action we recognize a specific and unequivocal right of the patient.

We must open our ICUs: not tomorrow but today. By opening our minds and reassessing our rituals and rules of a well-established and reassuring tradition, we can make a difference for our ICU patients and their families. The complex and highly technological environment of the ICU can and must become a welcoming place, which respects the needs of patients and families, and where ‘humanity has a high priority’ [1].

Conflicts of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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Table 1 *Key points from recommendations and position statements on visiting in ICU made by scientific Societies, Institutions and Committees*

Document	Country	Year	Key points
American College of Critical Care Medicine (ACCM) and Society of Critical Care Medicine (SCCM) [1]	USA	2007	• open visiting in the adult ICU allows flexibility for patients and families and is determined on a case-by-case basis; • patient, family, and nurse determine the visitation schedule collectively taking into account the best interest of the patient; • visiting in the PICU and NICU is open to parents and guardians 24 hrs a day; • pets are allowed to visit the ICU if they are clean and properly immunized; • ICU caregivers receive training in: - communication, conflict management and meeting facilitation skills; - assessment family needs and family members' stress and anxiety levels;
Institute for Patient and Family-Centered Care [2]	USA	2010	• develop 'visiting' guidelines supporting the presence of family based on patient's preferences; • acknowledge the important role of families and other 'partners in care' in the care process and use language of partnership, support, and mutual respect; • identify learning needs of staff to support change in practice and provide education;
American Association of Critical Care Nurses (AACN) [3]	USA	2011	• facilitate unrestricted access of hospitalized patients to a chosen support person (eg, family member, friend, or trusted individual) according to patient preference; • ensure a written protocol for allowing a patient's support person to be at the bedside; • ensure that policies prohibit discrimination based on age, race, ethnicity, religion, culture, etc.;
British Association of Critical Care Nurses (BACCN) [4]	United Kingdom	2012	• patients should expect: - to have their privacy, dignity and cultural beliefs recognized; - the choice of whether or not to have visitors; - the choice to decide who they want to visit including children and other loved ones; - the choice of care assisted by their relatives; - a critical care team who recognize the importance and value of visiting; • relatives should have: - access to (written) information regarding critical illness, aftercare and support; - timely information and regular updates about the patient's condition; - a comfortable and accessible waiting room; - an area for private discussions with health professionals;
National Committee for Bioethics [5]	Italy	2013	• ICU organization must promote the right of patients to have near them family members or loved ones; • patients must be consulted as to which persons they want to have near them; • family members must be given the possibility of being close to the patient in ICU; • ICU doctors and nurses need appropriate training (communication skills, conflict management, etc); • the Health Authority must undertake to promote and support implementation of the 'open' ICU model;

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