ICU
MANAGEMENT & PRACTICE

Preventing the misuse of ICU visiting hours to reduce inequities

Family participation in healthcare serves to improve outcomes across a broad spectrum of conditions. Current guidelines recommend open family presence in the intensive care unit (ICU) while citing evidence of its safety. However, many ICUs continue to impose limitations on families' access to their loved ones, a move that is viewed as promoting social injustice.

"In a society rife with implicit bias, restrictions on family visitation risk selective enforcement of these rules, and further propagates social injustice. Restrictions on family presence, including rigid hours, reflects an arbitrary vision based on increasingly obsolete socioeconomic realities," according to an article in Annals of the American Thoracic Society.

The article explains that visiting hours policies are not self-enforcing: rules are enforced by individuals, and the enforcement may frequently become selective. Thus in a medical system already besieged by inequities in care, visitation policies become another way in which the healthcare system creates injustice.

Traditional adult ICU visiting hours typically limit visits to a few hours in the late morning and the afternoon. Families are often excluded during early morning hours, under the well-meaning logic of giving teams time to do morning hand-offs and rounds. A variety of rationales are given, supposing limiting access of families to their loved ones benefits both groups.

Not only are these restrictions discordant with published data and guidelines, they are poorly aligned with growing reality of many Americans' work realities, according to the article, citing the following data: about one third work 45 hours or more each week; 29% work weekends. Nonstandard and contingent work has increased as well. These increasingly variable American work hours and challenges of obtaining leave misalign with stagnant visiting hours.

"For many families, restrictive visiting hours look more like another institutional wall excluding them from those they love. This exclusion from their lives comes at the moment when their family members are at their most vulnerable. These barriers are highest for those families with the fewest economic resources and the least job flexibility — for example, those without family leave or those without financial means for day care or additional caregiving," the article says.

Further, in a nation in which many individuals and states did not recognise marriage between same-sex couples — and many may still not approve of these relationships — visiting hours create an opportunity to selectively enforce the presence of these same-sex loved ones at the bedside. This adds injury to the insult of these same-sex couples, who are less likely than those in opposite-sex relationships to have health insurance, and more likely to have unmet healthcare needs, the article points out.

In the article, authors Giora Netzer, MD, MSCE (Division of Pulmonary and Critical Care Medicine, University of Maryland in Baltimore) and Theodore J. Iwashyna, MD, PhD, Division of Pulmonary and Critical Care Medicine, University of Michigan in Ann Arbor) propose that the obligation to protect the integrity and needs of our patients and families extends past our immediate relationship to them at the bedside, and is also a societal imperative.

"The time is now to open our ICUs both on behalf of our patients and families, and for the betterment of our society as a whole," the authors write. "As physicians and researchers, we advocate that open presence provides optimal care to our patients and their loved ones, backed by evidence and expert consensus. Guidelines exist to successfully implement this approach, with safeguards for exceptions as they may occur (e.g., abusive or disruptive family members, communicable infection outbreaks). Similarly, with unlimited presence, safeguards are needed to insure environmental hygiene and sleep."

Source: Annals of the American Thoracic Society
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