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Visitors in the ICU: Pros and Cons of Unrestricted Visitation

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Introduction

"Patient- or family-centred care" is a popular term favoured currently by ICU management teams. However, what is often overlooked is that in a niche environment with few limits, the latter not only implies that high-standard diagnostic and therapeutic care will be provided, but also that extended needs of the patient and his proxies as well will be met as well (Azoulay et al. 2001, Vandijck et al. 2007a). Patients and families place high value on the presence and support of loved ones. For both, this has been associated with a decreased level of stress and increased comfort (Abbott et al. 2001). Notwithstanding this, the vast majority of adult ICUs in Europe and the United States place restrictions on visitation. In a French study by Quinio and collaborators, 97% of ICUs reported restricted visits, allowing the patient proxies at only one (33%), two (62%), or respectively three (2%) prearranged access periods (Quinio et al. 2002). Accordingly, a study of our own group found that all Flemish adult medical, surgical, cardiocirculatory and mixed ICUs, including units for severely burned patients had restricted visiting policies (Vandijck et al. 2007b). Nevertheless, cultural contexts should not be underestimated, as demonstrated by an excellent study of Lee and collaborators conducted in New England, reporting open visitation in about one third of ICUs, and a Swedish study in which no less than 70% of participating ICUs reported no restrictions at all (Knutsson et al. 2004, Lee et al. 2007). Contrary to unrestricted visitation, restricted visitation can be characterised by a policy that imposes limits on access, time, and number of visitors, or excluding the presence of proxies in particular cases (Giannini 2007). A multitude of arguments are opposed to this, which will be highlighted below.

Unrestricted Visitation: Pros

To date, there is no scientific evidence to support arguments to keep the doors of the ICUs "closed". For instance, the fact that open ICU visitation policies coincide with increasing infection rates among either patients or proxies is a myth (Burchardi 2002). Rather, it has been shown that it is contact between patient and ICU staff which is the major risk factor, and efforts aimed to achieve totally inefficient (Giannini 2007). Further, the presence of proxies does not necessarily interfere with patient care or treatment as they may be involved in particular caring tasks, may help in facilitating mutual communication between staff and patient, and may give emotional support throughout difficult moments (Young and Plotkin 2000). As such, the presence of patient proxies can have a rather positive impact on patients by decreasing anxiety, stress, and also by creating a serene atmosphere in cases in which the patient is dying (Abbott et al. 2001, Fumagalli et al. 2006, Levy 2001).

Lastly, reserving adequate time to make open and respectful dialogue possible between all healthcare workers involved in patient care is of the utmost importance. By providing proxies with honest, direct, and patient-specific information most misunderstandings will be prevented, and will increase proxies' faith in the whole ICU team (Azoulay et al. 2000).

To date, few efforts have been undertaken to incorporate many of these findings into practice, although, mainly in paediatric ICUs, the idea of unrestricted visitation is becoming more accepted. Patients, proxies and ICU staff must see the mutually beneficial possibilities of working together to meet each other needs (Figure 1).

Unrestricted Visitation: Cons

Visiting policies are often developed by nursing staff, and their attitudes and concerns are amongst the strongest barriers to overcome for ICU managers who aim to liberalise visitation in their ICUs. Several studies report ICU nurses convictions and negative beliefs toward unrestricted visitation (Berti et al. 2007, Kirchhoff et al. 1993, Marco et al. 2006).

Reasons include nurses' fear of interference with nursing care planning, treatment, direct patient care, and increase of workload, as well as more time spent in providing information to patient proxies, higher levels of stress for the patient and his relatives, and violation of privacy. Additionally, a higher risk of infection for the patient and also for family members is often noted, the need to protect proxies (especially children) in troublesome treatment situations, as well as difficult experiences and feelings of discomfort in dealing with families overall are other arguments which are raised against opening the doors.

Conclusion

Although empirical research indicates that unrestricted visitation is associated with better patients' recovery, fewer physical and psychological complications, reduced emotional stress, and more satisfactory social standards, many ICU managers and staff remain sceptical toward opening their ICUs. However, the main objective should not be provide unrestricted visitation regardless of extenuating circumstances, but to consider all factors in collaboration with both patients and their proxies so that decisions on visits benefit all parties involved.



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