Intensive Care Med (2002) 28:1371–1372
DOI 10.1007/s00134-002-1401-8

EDITORIAL

H. Burchardi

Let's open the door!

Received: 4 June 2002
Accepted: 5 June 2002
Published online: 18 July 2002
© Springer-Verlag 2002

H. Burchardi (✉)
Zentrum Anaesthesiologie,
Rettungs- und Intensivmedizin, University Hospital,
Robert-Koch-Strasse 40, 37075 Göttingen, Germany
e-mail: hburcha@gwdg.de
Tel.: +49-551-396027, Fax: +49-551-396530

A recent survey of 95 intensive care units in France [1] has revealed some restrictive visiting policies in nearly all of them. For example, in 97% there were limited visiting hours, in 90% the number of visitors was restricted, in 55% children were not (or were only restrictively) allowed to visit their relatives, and in 40% only immediate relatives were permitted. We all should be grateful that this matter has been called to our attention. It is time to think over our relationship with our patients and their families and friends. Back in 1993 the United States American Association of Critical Care Nurses (AACN) held a consensus conference on fostering a more humane critical care [2]. Apparently, caregivers' perceptions are slowly changing. At least the needs of the families are now well noticed [3].

In my view, there are five good reasons to open the ICUs for relatives and visitors:

1. Opening the ICU to Ïthe public does not pose a medical risk. We know that ICUs are sites with a high risk of infection. However, this is due mainly to nosocomial infections [4]. The incidence of nosocomial infections in ICUs is five to ten times higher than the incidence in general wards [5]. The European Prevalence of Infection in Intensive Care (EPIC) study, a prevalence study conducted in 1417 ICUs in 17 European countries in 1992, found that 45% of the ICU patients were infected and 21% had ICU-acquired infections, often with multiresistant micro-organisms [6]. In a more recent epidemiological European study in 14,364 ICU patients, 21% already had infections on admission [7]. Of those previously without infection, 8% acquired an infection during their ICU stay. One-half of the ICU-acquired infections, however, occurred in patients already infected when they were admitted to the ICU. It is generally accepted that the predominant risk of infection is the transfer of microorganisms from patient to patient by caregivers' activities. Therefore consistent and frequent handwashing is recommended as the most important preventive measure. The risk of nosocomial infections is not caused by visitors from outside the hospital. Even protective clothing for visitors (including shoes) is not recommended as a measure of infection control [8]; it may, however, have some psychological effects for the visitors to bear in mind the special conditions of an ICU. Consequently we opened our ICU to visitors many years ago. They are allowed to come more or less whenever they want (except some busy hours during medical rounds). Our team is now accustomed to the fact that most of the time there are visitors and relatives present. At most, the team members sometimes complain of being held up in their routine work – but, honestly, we should be ashamed of such arguments! An important improvement would be some intimate place in all ICUs, close to the unit, where visitors can wait, relax, and contemplate, and where they can have confidential conversations with nurses and physicians. We must never forget that relatives are often exposed to unexpected grief and sorrow in the ICU.

2. Repeated communication with relatives is an essential part of the medical information process. Providing information and guidance is an important part of our medical mission. The goal is not merely to provide information about the disease and our medical activities. Even more important is the creation of a relationship of trust and confidence with the relatives. This may be even more important in intensive care than anywhere else, because of the mostly acute and threatening characteristic of the situation. Open-minded and compassionate conversation with family members creates confidence much more effectively than a businesslike, hasty transmission of objective facts. Building up such a confidential relationship takes time. Both sides must learn to understand the other.

But time is short – sometimes too short if problems are as complex and complicated as they often are in intensive care medicine. Therefore we should make use of the opportunities we have – and open up our ICUs.

3. Family members may help the patient to endure the difficult period of intensive care. Building understanding and trust between the family members and the medical team may help relatives to endure difficult situations. This in turn supports the family in their difficult task of comforting the critically ill – and may profoundly facilitate our medical care. We often find family members adapting well to the daily clinical routine and becoming really useful partners of the medical team during the critically ill patient's prolonged stay in the ICU.

4. Relatives play an important role in comforting the dying patient. The death of a critically ill patient is always a stressful episode for the family. The presence of family members or friends during the process of dying should be made possible whenever feasible. In my experience, relatives sometimes need to be persuaded to participate, since personal experience with death has somehow been suppressed in our modern society. Ultimately, however, the family members place a profound value on the possibility of being with their loved one, and this again helps the intensive care team, removing some of their burden. Finally, participating in such fundamental events of human life can greatly benefit the intensive care team as well. After all, this may have been one of the primary motivations for many of us. It is profoundly touching to read a note of gratitude addressed to the intensive care team in the newspaper obituary for a patient who died in the ICU.

5. Opening ICUs to the public is in our own interest. Last but not least, it is in our own interest to open the ICU. Intensive care has been slandered, reduced in the public opinion to "inhuman" or "high-tech" medicine. We all know that this is unfair and that, on the contrary, nursing care here is more intensive than anywhere else in the hospital. It is for this reason that human resources consume the largest portion (60–70%) of the expenses for intensive care medicine. By opening our ICUs to relatives we can demonstrate how much is being done for their family members, and how "intensive" the individual intensive care can be!

Additionally, intensive care has changed fundamentally during the past decade. At least in Europe the common strategy in mechanical ventilation, with the increasing use of partial spontaneous breathing, now reduces the need for deep sedation more and more [9]. Thus communication with the patient is becoming possible. For nurses used to caring for unconscious patients, it may take some time to accept the new situation and to learn how to deal with it. But once they are accustomed to it, they will certainly appreciate caring for communicative individuals instead of for unconscious human beings.

After many years of experience our intensive care team is happy with our "open" ICU (in the European sense: open for visitors). The change required some adaptation, particularly for the nursing team, who are always more directly involved with the family. But now we do not want to go back again. It is time to acknowledge that the ICU must be a place where humanity has high priority. It is time to open those ICUs which are still closed. Everyone – patients, families, and the whole intensive care team – will benefit. The ICU must not be a restricted area any longer! The survey by Quinio and coworkers should stimulate us to face what is necessary to make the next move!

References

1. Quinio P, Savry C, Deghel A, Guilloux M, Catineau J, Tinteniac AD (2002) A multicenter survey of visiting policies in French intensive care units. Intensive Care Med (http://dx.doi.org/10.1007/s00134-002-1402-7)
2. Harvey MA, Ninos NP, Adler DC, Goodnough-Hanneman SK, Kaye WE, Nikas DL (1993) Results of the consensus conference on fostering more humane critical care: creating a healing environment. Society of Critical Care Medicine. AACN. Clin Issues Crit Care Nurs 4:484–549
3. Azoulay E, Pochard F, Chevret S, Lemaire F, Mokhtari M, Le Gall JR, Dhainaut JF, Schlemmer B (2001) Meeting the needs of intensive care unit patient families: a multicenter study. Am J Respir Crit Care Med 163:135–139
4. Richards MJ, Edwards JR, Culver DH, Gaynes RP (1999) Nosocomial infections in medical intensive care units in the United States. National Nosocomial Infections Surveillance System. Crit Care Med 27:887–892
5. Widmer AF (1994) Infection control and prevention strategies in the ICU. Intensive Care Med 20 [Suppl 4]:7–11
6. Vincent J, Bihari D, Suter P, Bruining H, White J, Nicolas-Chanoin M, Wolff M, Spencer R, Hemmer M (1995) The prevalence of nosocomial infection in intensive care units in Europe. JAMA 274:639–644
7. Alberti C, Brun-Buisson C, Burchardi H, Martin C, Goodman S, Artigas A, Sicignano A, Palazzo M, Moreno R, Boulme R, Lepage E, Le Gall R (2002) Epidemiology of sepsis and infection in ICU patients from an international multicentre cohort study. Intensive Care Med 28:108–121
8. Goldmann DA (1991) The role of barrier precautions in infection control. J Hosp Infect 18 [Suppl A]:515–523
9. Rathgeber J, Schorn B, Falk V, Kazmaier S, Spiegel T, Burchardi H (1997) The influence of controlled mandatory ventilation (CMV), intermittent mandatory ventilation (IMV) and biphasic intermittent positive airway pressure (BIPAP) on duration of intubation and consumption of analgesics and sedatives. A prospective analysis in 596 patients following adult cardiac surgery. Eur J Anaesthesiol 14:576–582